

Exhibit 9
to
Declaration of Declaration of Andrew S. Hansen
Ralph Simon v. Select Comfort Retail Corp.,
and Select Comfort Corporation
Case No.: 4:14-cv-1136 (JAR)

Dr. Ernest Chiodo
August 20, 2015

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

RALPH SIMON,)	
)	
Plaintiff,)	
)	
vs.)	No.
)	4:14-cv-1136
SELECT COMFORT RETAIL,)	(JAR)
CORP.,)	
)	
and)	
)	
SELECT COMFORT)	
CORPORATION,)	
)	
)	
Defendants.)	

The discovery deposition of
DR. ERNEST CHIODO, called by the
Defendants, for examination, pursuant to
notice, taken before LAURA MUKAHIRN, CSR, a
notary public within and for the County of
Cook and State of Illinois, at 227 West
Monroe Street, Chicago, Illinois, on
August 20, 2015, scheduled to commence at
10:40 o'clock a.m.

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<p>1 APPEARANCES:</p> <p>2 SHER CORWIN WINTERS</p> <p>3 190 Carondelet Plaza</p> <p>4 Suite 1100</p> <p>5 St. Louis, Missouri 63105</p> <p>6 (314)721-5200</p> <p>7 BY: MR. DAVID S. CORWIN</p> <p>8 Appeared on behalf of the</p> <p>9 Plaintiff;</p> <p>10</p> <p>11 OPPENHEIMER WOLFF & DONNELLY LLP</p> <p>12 Campbell Mithun Tower</p> <p>13 222 South Ninth Street</p> <p>14 Suite 2000</p> <p>15 Minneapolis, Minnesota 55402-3338</p> <p>16 (612)607-7450</p> <p>17 BY: MS. HEIDI A. O. FISHER</p> <p>18 Appeared on behalf of the</p> <p>19 Defendants;</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>1 (Witness sworn.)</p> <p>2 DR. ERNEST CHIODO,</p> <p>3 called as a witness herein, having been</p> <p>4 first duly sworn, was examined and</p> <p>5 testified as follows:</p> <p>6 Examination</p> <p>7 By Ms. Fisher</p> <p>8 Q. Good morning, Dr. Chiodo. Did</p> <p>9 I say that right?</p> <p>10 A. Yes, ma'am. That's fine.</p> <p>11 Q. Chiodo?</p> <p>12 A. I say Chiodo, but don't worry.</p> <p>13 Everybody in my family pronounces it</p> <p>14 differently.</p> <p>15 Q. I'm going to try to recall that</p> <p>16 as we move on. We met previously. My name</p> <p>17 is Heidi Fisher. I'm an attorney with</p> <p>18 Oppenheimer, Wolff & Donnelly out of</p> <p>19 Minneapolis, and I represent Select Comfort</p> <p>20 Corporation and Select Comfort Retail</p> <p>21 Corporation in this litigation.</p> <p>22 You understand you're at a</p> <p>23 deposition today to answer questions in the</p> <p>24 case of Ralph Simon vs. Select Comfort.</p> <p>25 When I say Select Comfort, I'm going to</p>
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<p>1 INDEX</p> <p>2 Examinations Page</p> <p>3 Examination 4</p> <p>4 By Ms. Fisher</p> <p>5</p> <p>6 EXHIBITS</p> <p>7 No. Page</p> <p>8 Dr. Chiodo Exhibit No. 1 12</p> <p>9 Dr. Chiodo Exhibit No. 2 66</p> <p>10 Dr. Chiodo Exhibit No. 3 79</p> <p>11 Dr. Chiodo Exhibit No. 4 90</p> <p>12 Dr. Chiodo Exhibit No. 5 96</p> <p>13 Dr. Chiodo Exhibit No. 6 110</p> <p>14 Dr. Chiodo Exhibit No. 7 143</p> <p>15 Dr. Chiodo Exhibit No. 8 147</p> <p>16 Dr. Chiodo Exhibit No. 9 150</p> <p>17 Dr. Chiodo Exhibit No. 10 152</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>1 refer to both Select Comfort Retail</p> <p>2 Corporation and Select Comfort Corporation.</p> <p>3 Can you state your entire name</p> <p>4 for the record, please?</p> <p>5 A. Ernest Paul Chiodo,</p> <p>6 C-H-I-O-D-O.</p> <p>7 Q. And, Mr. Chiodo -- or</p> <p>8 Dr. Chiodo, I understand you've been</p> <p>9 deposed multiple times before?</p> <p>10 A. Yes, ma'am.</p> <p>11 Q. So I'm going to dispense with</p> <p>12 most of the preliminary instructions with</p> <p>13 respect to depositions. If at any time you</p> <p>14 misunderstand my question, just please ask</p> <p>15 me to rephrase, or need to take a break.</p> <p>16 And I think with that, we'll just get</p> <p>17 started.</p> <p>18 Where do you currently live?</p> <p>19 A. My domicile is Michigan,</p> <p>20 suburban Detroit. But I do have homes and</p> <p>21 offices in Chicago and West Palm Beach,</p> <p>22 Florida, in addition to suburban Detroit.</p> <p>23 Q. You said homes and businesses.</p> <p>24 Let's talk about your businesses first.</p> <p>25 What business do you -- Do you have a</p>

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<p>1 business in Michigan?</p> <p>2 A. Well, I don't call it a</p> <p>3 business. I call it a practice. But I</p> <p>4 have a professional office in Clinton</p> <p>5 Township Michigan.</p> <p>6 Q. Okay. When you say</p> <p>7 professional office, is that a medical</p> <p>8 office or a legal office?</p> <p>9 A. Both.</p> <p>10 Q. Okay. Same office for both</p> <p>11 practices?</p> <p>12 A. Yes. Yes, ma'am. I'm</p> <p>13 obviously not the attorney for people that</p> <p>14 I'm their physician, and not the physician</p> <p>15 for the people that I'm their attorney.</p> <p>16 Q. Understood. You have a</p> <p>17 business in Florida. Can you tell me about</p> <p>18 that a little bit?</p> <p>19 A. I have a professional practice</p> <p>20 there. I'm not practice -- I'm not</p> <p>21 licensed to practice law in Florida, so my</p> <p>22 practice is my practice other than the</p> <p>23 practice of law. When I say "my practice,"</p> <p>24 my practice includes being a physician and</p> <p>25 a physician utilizing my various other</p>	<p>1 to have some type of litigation going on;</p> <p>2 third-party litigation or workers' comp</p> <p>3 litigation. So that's part and parcel of</p> <p>4 occupational medicine. It's not with other</p> <p>5 personalities like general internal</p> <p>6 medicine. I don't do any general internal</p> <p>7 medicine in Florida. I do have a small</p> <p>8 general internal medicine practice in</p> <p>9 Michigan. And then those patients I would</p> <p>10 say none of them have any litigation going</p> <p>11 on.</p> <p>12 Q. Okay. With respect to your --</p> <p>13 A. None that I know of.</p> <p>14 Q. With respect to your Florida</p> <p>15 business, you say you just opened the</p> <p>16 office. When was that?</p> <p>17 A. Probably had the office for</p> <p>18 about a year, but setting things up and</p> <p>19 just started seeing people -- started kind</p> <p>20 of -- started taking people into the</p> <p>21 occupational medicine practice recently.</p> <p>22 Within the last couple months.</p> <p>23 Q. Okay. With respect to the</p> <p>24 patients that you've seen within the last</p> <p>25 couple months, are they plaintiffs or</p>
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<p>1 expertise: Biomedical engineering,</p> <p>2 industrial hygiene, toxicology,</p> <p>3 epidemiology. So I maintain a medical</p> <p>4 office in West Palm Beach, Florida.</p> <p>5 Q. What is the focus of that</p> <p>6 practice in West Palm Beach, Florida?</p> <p>7 A. The focus of that practice is</p> <p>8 where I have a clinical relationship, that</p> <p>9 would be a physician/patient relationship,</p> <p>10 with individuals is occupational and</p> <p>11 environmental medicine and toxicology.</p> <p>12 Q. What percentage of the patients</p> <p>13 in your West Palm Beach, Florida business</p> <p>14 are litigants or potential litigants in a</p> <p>15 court case?</p> <p>16 A. I think it would be 100</p> <p>17 percent, because I just opened up that</p> <p>18 office. And the people that I've dealt</p> <p>19 are -- have some litigation going on, which</p> <p>20 is not unusual with occupational medicine.</p> <p>21 Because occupational medicine is one of</p> <p>22 those specialties that if you're -- you are</p> <p>23 uncomfortable with being deposed, you don't</p> <p>24 want to do that specialty. Because</p> <p>25 virtually every patient you have is going</p>	<p>1 defendants or -- I'm sorry. Are they all</p> <p>2 plaintiffs or were you hired by the defense</p> <p>3 in any of those cases?</p> <p>4 A. Well, if I was hired by</p> <p>5 defense, then I'm not their doctor. So</p> <p>6 what I'm referring to is where I have a</p> <p>7 physician/patient relationship with the</p> <p>8 individual. Now, I've done in Florida</p> <p>9 other work as a forensic expert, and there</p> <p>10 I would say the vast majority of my work in</p> <p>11 Florida has been as a defense expert.</p> <p>12 Because not only toxin and occupational</p> <p>13 environmental medicine cases, usually mold</p> <p>14 cases, but also -- I'm also a biomedical</p> <p>15 engineer. So I get involved in vehicular</p> <p>16 impact biomechanics cases. And in those</p> <p>17 cases I'm almost always a defense expert.</p> <p>18 Q. When you say mold cases, is it</p> <p>19 your testimony that you're usually a</p> <p>20 defense expert in mold cases?</p> <p>21 A. No. It's just that the cases</p> <p>22 where I've been down in Florida to date I</p> <p>23 would say -- I'm trying to think about how</p> <p>24 many cases. It's hard for me to say. I</p> <p>25 would be guessing, and I'm not supposed to</p>

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<p>1 guess. But I don't recall, as I'm sitting</p> <p>2 here, being an expert for plaintiff in a</p> <p>3 mold case as of date. I have been an</p> <p>4 expert for defense in mold cases, in at</p> <p>5 least a couple mold cases that I can think</p> <p>6 of, I can think of offhand.</p> <p>7 Q. So your total number of mold</p> <p>8 cases would be -- would you put it under</p> <p>9 five?</p> <p>10 A. I would say it would be in that</p> <p>11 general magnitude.</p> <p>12 MR. CORWIN: In Florida?</p> <p>13 THE WITNESS: In Florida.</p> <p>14 BY MS. FISHER:</p> <p>15 Q. In Florida. Okay. How about</p> <p>16 elsewhere?</p> <p>17 A. Oh, quite a few. I mean</p> <p>18 it's --</p> <p>19 Q. More than 50?</p> <p>20 A. No. I don't know if it would</p> <p>21 be -- I would be guessing, but it's</p> <p>22 something that comes up not infrequently.</p> <p>23 Q. In a little while we'll take a</p> <p>24 look at your CV and you can -- Would you be</p> <p>25 able to, by looking at your CV, figure out</p>	<p>1 Chiodo 1.</p> <p>2 (Document marked as Dr.</p> <p>3 Chiodo Exhibit No. 1 for</p> <p>4 identification.)</p> <p>5 THE WITNESS: And, of course,</p> <p>6 the Federal Rule 26 testimony was only</p> <p>7 those cases where I provided testimony, not</p> <p>8 necessarily cases where I'd been involved</p> <p>9 or retained as an expert.</p> <p>10 BY MS. FISHER:</p> <p>11 Q. Have you ever been retained as</p> <p>12 an expert or asked to be an expert, and</p> <p>13 after your initial assessment you've</p> <p>14 advised that with respect to plaintiffs you</p> <p>15 don't have a case?</p> <p>16 A. Yes. In fact, that's usually</p> <p>17 my mode, that if -- I have a flat fee</p> <p>18 typically. And if I don't believe that I</p> <p>19 can be the expert, I give them back their</p> <p>20 money, and that has happened. I can't</p> <p>21 recall specific times. But, you know,</p> <p>22 there's a flat fee, but you obviously -- I</p> <p>23 don't know whether I'm going to be able to</p> <p>24 be plaintiff or defense expert until I've</p> <p>25 done my review.</p>
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<p>1 which ones of those were related to mold?</p> <p>2 A. CV, no.</p> <p>3 Q. Or your list of cases?</p> <p>4 A. I brought a Federal Rule 26</p> <p>5 testimony list. I may or -- I may or may</p> <p>6 not be able to. If you want go through it,</p> <p>7 I can see if I -- if it rings a bell.</p> <p>8 Q. Yeah. Why don't we go through</p> <p>9 that right now, as long as we're talking</p> <p>10 about it.</p> <p>11 A. I'm going to hand you, ma'am,</p> <p>12 both my current CV, and then underneath</p> <p>13 that is my current Federal Rule 26</p> <p>14 testimony.</p> <p>15 Q. Is this a copy for me?</p> <p>16 A. You can keep that.</p> <p>17 Q. And you have a copy in front of</p> <p>18 you?</p> <p>19 A. I do not.</p> <p>20 Q. Okay.</p> <p>21 A. I can loop around you, if you</p> <p>22 wish, to look over your shoulder.</p> <p>23 MS. FISHER: Let's go ahead and</p> <p>24 mark this Exhibit 1.</p> <p>25 MR. CORWIN: And we're doing</p>	<p>1 Q. And your flat fee is \$30,000?</p> <p>2 A. \$30,000 for a review of</p> <p>3 records, writing up reports, preparation</p> <p>4 for testimony. But not for testimony time,</p> <p>5 examination. Also it doesn't cover travel</p> <p>6 time; which, of course, there's really no</p> <p>7 travel time today, because it's just by my</p> <p>8 Chicago office.</p> <p>9 Q. Okay. So with respect to</p> <p>10 Exhibit 1, there's a portion of this that</p> <p>11 is, I would say, a little more than halfway</p> <p>12 through.</p> <p>13 A. About 26 pages or so.</p> <p>14 Q. Which starts at a new Page 1</p> <p>15 after -- it looks like after the CV that's</p> <p>16 entitled Testimony. This is your Rule 26</p> <p>17 testimony that we were just talking about?</p> <p>18 A. Yes, ma'am.</p> <p>19 Q. I'm going to hand it back to</p> <p>20 you.</p> <p>21 A. And if you want to look over my</p> <p>22 shoulder, that's fine, too.</p> <p>23 Q. Yeah. It appears to me -- I'm</p> <p>24 just going to -- I was reviewing the</p> <p>25 document you previously provided to see if</p>

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<p style="text-align: right;">Page 14</p> <p>1 it was the same with just a couple of</p> <p>2 additions, but it looks like there's more</p> <p>3 than just a few additions to it.</p> <p>4 A. Right.</p> <p>5 Q. Okay. Let's do it this way.</p> <p>6 I'll come to you. If you could tell me on</p> <p>7 this list, I don't know if you can put an X</p> <p>8 by anything there that, as you review the</p> <p>9 list, that related to mold?</p> <p>10 A. Okay. What I think what my</p> <p>11 suggestion is, we start at the back.</p> <p>12 Because my recollection will be clearer.</p> <p>13 Q. That works fine.</p> <p>14 A. X next to it?</p> <p>15 Q. Yeah. I handed the witness a</p> <p>16 pencil and he's going to mark it with an X</p> <p>17 next to each one of them.</p> <p>18 A. Mold case.</p> <p>19 Q. That happens to relate to a</p> <p>20 mold case to the best of his recollection.</p> <p>21 A. Yes, ma'am.</p> <p>22 Q. Thank you. Now, pursuant to</p> <p>23 Rule 26, this is your list of testimony in</p> <p>24 the last four years, correct?</p> <p>25 A. In the last four years.</p>	<p style="text-align: right;">Page 16</p> <p>1 different areas of activity.</p> <p>2 However, that being said, I</p> <p>3 recognize that you're entitled to some type</p> <p>4 of approximation. I don't know how much it</p> <p>5 is. However, I think it's a lot of what I</p> <p>6 do. It's a lot of my income. So I don't</p> <p>7 differ with the assertion that 90 percent</p> <p>8 or more of my income comes from being a</p> <p>9 forensic expert. I don't know that that's</p> <p>10 the case. It could be less. But if asked</p> <p>11 at trial the following question:</p> <p>12 Dr. Chiodo, do you differ with</p> <p>13 the assertion that 90 percent or more of</p> <p>14 your income comes from being a forensic</p> <p>15 expert? I will simply answer, no, I don't</p> <p>16 differ with that assertion.</p> <p>17 Now, if you start trying to</p> <p>18 play games with, well, percentage this, and</p> <p>19 take 90 percent. I didn't testify that it</p> <p>20 was 90 percent. I've had people try to do</p> <p>21 that. And they say, well, you said 90.</p> <p>22 And I said I won't differ with the</p> <p>23 assertion that it's 90 percent, but I don't</p> <p>24 know that that's the case. But just so</p> <p>25 that you have it clearly stated on the</p>
<p style="text-align: right;">Page 15</p> <p>1 Q. You have previous testimony,</p> <p>2 true?</p> <p>3 A. I do have previous testimony.</p> <p>4 But again, just to be clear, those are</p> <p>5 cases where I actually provided testimony,</p> <p>6 not cases where I have been retained and</p> <p>7 for whatever reason there was no testimony.</p> <p>8 Q. Okay. Understood. I'm going</p> <p>9 to handle this the same way you handled it</p> <p>10 so that things are more clear in your</p> <p>11 memory.</p> <p>12 And before I start with this,</p> <p>13 can you tell me how much of your income is</p> <p>14 derived from being an expert?</p> <p>15 A. I don't know, because I don't</p> <p>16 keep a log breaking it down that way. I</p> <p>17 mean I pay my taxes. My total income, the</p> <p>18 IRS doesn't need me to break down whether</p> <p>19 it's from being a forensic expert versus</p> <p>20 treating physician versus practicing law,</p> <p>21 teaching law, whatever. Because they give</p> <p>22 you a percentage, I'd have to have a -- I</p> <p>23 know my denominator, I know my gross</p> <p>24 income, but I don't have a log or keep a</p> <p>25 record to break it down based upon</p>	<p style="text-align: right;">Page 17</p> <p>1 record. Again, if you ask at trial the</p> <p>2 following question in this matter:</p> <p>3 Dr. Chiodo, do you differ with</p> <p>4 the assertion that 90 percent or more of</p> <p>5 your income comes from being a forensic</p> <p>6 expert? I will simply answer, no, I do not</p> <p>7 differ with that assertion.</p> <p>8 Q. Thank you. Let's first talk</p> <p>9 about the Moore Living Trust case. Home</p> <p>10 Sales vs. Bobbie Vocke, V-O-C-K-E. What</p> <p>11 can you tell me about that case?</p> <p>12 A. That was a case of a mobile</p> <p>13 home sold to an individual -- Actually,</p> <p>14 there were two individuals that it was sold</p> <p>15 to where there was mold contamination. And</p> <p>16 it appears that there was an attempt to</p> <p>17 conceal the mold contamination with paint.</p> <p>18 So I was retained by the plaintiffs in that</p> <p>19 matter.</p> <p>20 Q. What kind of mold was present</p> <p>21 in the mobile home?</p> <p>22 A. Just mold. Just mold. There</p> <p>23 was no claim concerning medical monitoring</p> <p>24 or health effects due to mold micro toxins.</p> <p>25 So the allergic effects of mold, there's no</p>

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<p style="text-align: right;">Page 18</p> <p>1 need to speciate. So if it's mold, any</p> <p>2 mold can cause allergic effects. The need</p> <p>3 to try to determine what type of molds were</p> <p>4 present, that comes into play if you're</p> <p>5 talking about disease or risk of disease</p> <p>6 due to mold micro toxins.</p> <p>7 Q. So this is -- This case was</p> <p>8 purely a fraud or breach of warranty or</p> <p>9 some sort or product case with no</p> <p>10 health-related issues?</p> <p>11 A. No. I think they were</p> <p>12 health-related issues, but they were</p> <p>13 health-issues related to the allergenic</p> <p>14 effects of mold and not due to the mold</p> <p>15 micro toxins.</p> <p>16 Q. So they were claiming health</p> <p>17 effects in this case?</p> <p>18 A. You know, I believe the actual</p> <p>19 case had to do with fraud concerning the</p> <p>20 product. But I think my testimony got into</p> <p>21 the issue of the minor child as to whether</p> <p>22 or not there would be some -- his health</p> <p>23 effects had a causal connection, either</p> <p>24 caused by or aggravated by mold exposure.</p> <p>25 So I did provide testimony along those</p>	<p style="text-align: right;">Page 20</p> <p>1 mold exposure was?</p> <p>2 A. No.</p> <p>3 Q. Why not?</p> <p>4 A. Because there are over 100,000</p> <p>5 different molds, and you're not going to</p> <p>6 test somebody for 100,000 different molds.</p> <p>7 There are mold antibody panels, but usually</p> <p>8 they have 10, maybe 20 molds on them. So,</p> <p>9 no, that's not -- That's not the approach.</p> <p>10 An occupational medicine doctor would not</p> <p>11 take that approach. They would say, okay,</p> <p>12 is there mold? And is somebody having</p> <p>13 disease manifestation consistent with</p> <p>14 hypersensitivity? And what's the exposure,</p> <p>15 what are the temporal manifestations?</p> <p>16 That's how it's done. It's not done by a</p> <p>17 simple test. If that were the case, there</p> <p>18 would be no need for occupational or</p> <p>19 environmental medicine doctors. The</p> <p>20 allergist could do it, but they can't do it</p> <p>21 because they don't have the background</p> <p>22 concerning industrial hygiene sorting out</p> <p>23 causation from an occupational</p> <p>24 environmental medicine perspective. That's</p> <p>25 a very specialized area of practice that</p>
<p style="text-align: right;">Page 19</p> <p>1 lines. Although I think the actual case,</p> <p>2 he was not included, because he was a</p> <p>3 minor. They may sue on that matter later</p> <p>4 for him, but I think the actual case was</p> <p>5 basically the fraud case. I don't handle</p> <p>6 the pleadings, but I think that's the</p> <p>7 nature of the claim.</p> <p>8 Q. So was it your assertion that</p> <p>9 in order to determine whether there's a</p> <p>10 causal effect with respect to the mold</p> <p>11 presence, it's not necessary to find out</p> <p>12 what kind of mold was present?</p> <p>13 A. If you're talking about the</p> <p>14 allergenic effects, that's correct.</p> <p>15 Q. What would you characterize as</p> <p>16 allergenic effects?</p> <p>17 A. Oh, effects due to</p> <p>18 hypersensitivity; that is, sinusitis,</p> <p>19 rhinitis, skin rash, asthma. The effects</p> <p>20 of the mold due to mold antigens and the</p> <p>21 body's reaction to mold antigens in an</p> <p>22 individual who is sensitized to that mold.</p> <p>23 Q. Well, wouldn't you need to know</p> <p>24 what mold antigens that individual is</p> <p>25 sensitized and compare that with what the</p>	<p style="text-align: right;">Page 21</p> <p>1 most physicians do not have, and that is</p> <p>2 not taught in medical school. To get that</p> <p>3 type of additional expertise, you have to</p> <p>4 have an additional degree in addition to a</p> <p>5 medical degree, and that's a Master of</p> <p>6 Public Health or something analogous to a</p> <p>7 Master of Public Health.</p> <p>8 Q. So you mention that you need to</p> <p>9 know the exposure. How do you know the</p> <p>10 exposure?</p> <p>11 A. Well, first off, there's -- Is</p> <p>12 there visible mold? If there's visible</p> <p>13 mold, there's mold contamination. And so</p> <p>14 there's visible mold, there's mold</p> <p>15 contamination. And looking at the</p> <p>16 circumstances, does that lead to an</p> <p>17 individual being exposed? Well, if there's</p> <p>18 visible mold on the first -- on one room on</p> <p>19 the first floor of a 30-floor high-rise,</p> <p>20 then there may not be mold exposure to</p> <p>21 somebody on Floor 30. But if there's</p> <p>22 visible mold in the area of an individual,</p> <p>23 the work area, their living area, and it is</p> <p>24 more than just a little bit of mold along</p> <p>25 the crevices in your shower, there's a mold</p>

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<p>1 contam -- visible mold contamination. Then</p> <p>2 that is manifestation of mold contamination</p> <p>3 and then that leads the occupational</p> <p>4 medicine doctor to be able to sort out</p> <p>5 whether or not disease manifestation was</p> <p>6 caused by or not caused by that exposure.</p> <p>7 Q. Do you need to know if there's</p> <p>8 mold exposure in the air so that the person</p> <p>9 can inhale it?</p> <p>10 A. No. In fact -- No. That's not</p> <p>11 the case. In fact, I'm going to cite to</p> <p>12 you, just so that -- and I'll tell you what</p> <p>13 I'm citing from.</p> <p>14 Q. Please.</p> <p>15 A. Bioaerosols: Assessment and</p> <p>16 Control by the American Conference of</p> <p>17 Governmental Industrial Hygienists. What</p> <p>18 is the American Conference of Governmental</p> <p>19 Hygienists? That is on organization that</p> <p>20 is not part of the U.S. government. It's</p> <p>21 not a governmental entity. However, it is</p> <p>22 a very well-respected entity. Its</p> <p>23 recommendations advise and guide</p> <p>24 governments throughout the world, including</p> <p>25 the U.S. government, concerning</p>	<p>1 growth in buildings is undesirable and may</p> <p>2 cause health problems for building</p> <p>3 occupants. Although it may be difficult to</p> <p>4 establish that exposure to fungal aerosols</p> <p>5 occurs or that exposure represents a</p> <p>6 hazard, indoor fungal growth is</p> <p>7 inappropriate and should be removed.</p> <p>8 Further steps should be taken to correct</p> <p>9 conditions that lead to fungal growth so</p> <p>10 that it does not occur."</p> <p>11 Now I'm going to get to the</p> <p>12 specific point. "Visible contamination</p> <p>13 that is confirmed by source sampling to be</p> <p>14 fungal growth is evidence of indoor</p> <p>15 contamination. Air sampling (culture or</p> <p>16 sport trap sampling) may also indicate</p> <p>17 indoor fungal growth, but should be</p> <p>18 followed by inspection and source sampling</p> <p>19 to identify the location of the fungal</p> <p>20 contamination."</p> <p>21 Section continues on to say,</p> <p>22 "In the presence of the inevitable</p> <p>23 background concentration, the challenge for</p> <p>24 environmental sampling is to detect indoor</p> <p>25 fungal growth or entry of fungal aerosols</p>
Page 23	Page 25
<p>1 occupational and environmental exposure</p> <p>2 standards. And to give an idea, when OSHA</p> <p>3 came into play in the early 1970s, the</p> <p>4 permissible exposure limits for chemicals</p> <p>5 adopted as law were the threshold limit</p> <p>6 values of the American Conference of</p> <p>7 Governmental Industrial Hygienists in 1968.</p> <p>8 So it's a well-respected organization.</p> <p>9 They have a publication called</p> <p>10 Bioaerosols: Assessment and Control. The</p> <p>11 copyright is 1999. However, within the</p> <p>12 last month or two I checked with them to</p> <p>13 see if this is still their current</p> <p>14 publication, and it is. So I believe that</p> <p>15 this is a reliable authority. If somebody</p> <p>16 is involved with mold issues, this tends to</p> <p>17 be the Bible, Bioaerosols: Assessment and</p> <p>18 Control.</p> <p>19 I'm reading now from section --</p> <p>20 It's not laid out in pages. It's laid out</p> <p>21 in sections, chapters and then sections.</p> <p>22 And I'm reading from the seventh chapter in</p> <p>23 Section 7.4.2, Fungi. Okay. It reads the</p> <p>24 following, "Many fungi produce allergens</p> <p>25 and some fungi produce toxins. Fungal</p>	<p>1 from sources near OAIs." I don't know what</p> <p>2 OAIs is referring to in this matter. I</p> <p>3 think it's the occupants. "And to document</p> <p>4 the distribution of such sources to</p> <p>5 occupant exposure. Interpretation of</p> <p>6 possible indoor fungal exposure has been</p> <p>7 addressed using, A, indoor/outdoor total</p> <p>8 concentration ratios; B, comparison of the</p> <p>9 species compositions indoors and outdoors;</p> <p>10 and, C, the presence of indicator species</p> <p>11 in the indoor environment."</p> <p>12 So what that passage means is,</p> <p>13 if you see visible mold contamination, it</p> <p>14 is mold contamination. You don't need, nor</p> <p>15 would it be appropriate, to do air testing.</p> <p>16 Air testing is for when you go into a</p> <p>17 building and somebody -- people think that</p> <p>18 they are having problems related to mold</p> <p>19 and you want to know whether there's mold</p> <p>20 contamination. So you do air testing</p> <p>21 indoors and outdoors, you speciate them so</p> <p>22 that you can do a comparison to see the</p> <p>23 species. Are the species indoors similar</p> <p>24 to those outdoors, or is there a difference</p> <p>25 indicating mold contamination. So if you</p>

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<p>1 have visible mold, you don't do air 2 testing. It's just not indicated. 3 Q. It's not indicated by your 4 profession? 5 A. By the profession. And, as 6 I've just indicated, visible mold 7 contamination is confirmed by source 8 sampling to be fungal growth is evidence of 9 indoor contamination. Now, I realize this 10 case we're talking about a bed. Usually 11 they don't write books on bed 12 contamination. 13 Q. That was going to be my next 14 question. The -- What they're discussing 15 in that book is mold contamination in 16 buildings and walls and things of that 17 nature. Isn't that true? 18 A. Or things in buildings. I 19 understand in this matter, the bed was in a 20 building. In any event, visible mold 21 contamination confirmed by sampling, which 22 was the case here, is mold contamination. 23 To do air testing just simply doesn't 24 apply, and is either an intentional red 25 herring or a statement by somebody that</p>	<p>1 permeate through the bottle, there's no 2 exposure. There may be a hazard. There 3 may be something that you're concerned 4 about. You don't want it to break open. 5 But I'm not going to get sick if I don't 6 have exposure. 7 So I think that goes to your -- 8 the essence of your question. If you have 9 mold and it's contained, it truly is 10 contained, there's no exposure, then 11 somebody is not going to get sick due to 12 mold exposure. However, I don't believe 13 that refers to the scenario in this matter, 14 and it doesn't, in general, refer to 15 buildings in general. For example, I've 16 had involvement in claims where somebody 17 will say, well, the mold is behind the 18 wall, so nobody should get sick. No, 19 that's -- You can still have exposure 20 through movement of air and the spores from 21 mold behind the wall. And the standard is 22 that you have to remove the mold behind the 23 wall. You just can't paper over it. 24 Q. So there -- So you would agree 25 with me that if there's mold contamination,</p>
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<p>1 doesn't understand the process. 2 Q. Let me give you a hypothetical. 3 If I were to soak a beach towel with all 4 the good things that mold liked to eat and 5 zip it up in a plastic bag and allow it to 6 grow mold. And you can see through the 7 plastic bag visible mold contamination, but 8 we know that that mold cannot get outside 9 of the plastic bag, would it still pose a 10 health risk to those standing outside the 11 plastic bag? 12 A. If it's impermeable, no, it 13 would not. Now, I think it's completely 14 different than the fact scenario in this 15 matter. But to answer your question -- and 16 I think it's more general. If you have a 17 hazard. Say I have this bottle, this 18 plastic bottle. 19 Q. The witness is holding up his 20 plastic water bottle. 21 A. I'm holding up a plastic water 22 bottle. And this was filled, instead of 23 with water, some very toxic substance, and 24 it's hazardous. But if the substance is 25 contained in this water bottle, it doesn't</p>	<p>1 there must be a path to exposure? 2 A. You have to -- Yeah, you have 3 to have exposure. That's really a general 4 principal within industrial hygiene and 5 toxicology, that you have to have some path 6 of exposure, which I believe is the case in 7 this matter. Experts on the other side may 8 not agree with that, but I believe that 9 there was exposure. 10 Q. And one thing that I heard you 11 read from your book there was there's a 12 comparison -- it's helpful to do a 13 comparison between indoor and outdoor 14 concentrations. Isn't it true that often, 15 though the indoor air test done and that 16 compared in the same time of day on the 17 same day to an outdoor concentration, so 18 that one can determine whether or not the 19 level of mold indoors is actually higher 20 than the level of the normal outdoor 21 concentration of mold, and that that is an 22 indication that there's indoor exposure as 23 opposed to outdoor exposure just coming in? 24 A. Well, as I've testified 25 earlier, if you go into -- and I'm going to</p>

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<p style="text-align: right;">Page 30</p> <p>1 use -- use buildings for an example, 2 because that's the usual case. It's sort 3 of unusual to have a circumstance where you 4 have a hidden defect as you do in this 5 matter that's a bed. This is sort of an 6 unusual circumstance. But say I go into a 7 building and there's mold growing on the 8 wall. You can see the visible mold and you 9 test it and it is mold. It's not just some 10 dirt, then that's mold contamination. You 11 don't do air testing unless you say, okay, 12 fine, I want to clean this visible mold up. 13 I want to make sure I got rid of it all. 14 Then you could do air testing as clearance 15 testing. But there would be no indication 16 to go forward and say, well, fine, there's 17 visible mold, there's mold contamination, 18 but then let's do air testing. That is 19 done, but it's not properly done. Because 20 why would you do the indoor and outdoor air 21 testing? 22 Now, back to your specific 23 statement. It's more than just saying 24 there's higher levels indoors or outdoors. 25 You also compare the different species.</p>	<p style="text-align: right;">Page 32</p> <p>1 good to have external confirmation. 2 If you go to the Reference 3 Manual of Scientific Evidence, Third 4 Edition, from the Federal Judicial Center 5 and the National Research Council, National 6 Research Council. National Research 7 Council is made up of the National 8 Academies of Science, National Academies of 9 Engineering and Institute of Medicine. 10 It's a joint publication. It's a joint 11 publication meant for judges, primarily 12 federal judges, but also state judges to 13 rule out, to kind of -- I shouldn't say 14 rule out. To assess scientific testimony, 15 qualifications of experts who give 16 scientific testimony, what should be done, 17 proper methodologies. So what one does in 18 a matter like this, because, you know, 19 there's mold -- there's mold everywhere, 20 but there's not mold contamination 21 everywhere. Virtually everywhere that's 22 mold, but there's not mold contamination 23 everywhere. So how does one, as a 24 physician, sort out mold -- whether or not 25 some person is due to mold exposure due to</p>
<p style="text-align: right;">Page 31</p> <p>1 But, in general, you should have the same 2 types of mold and mold species indoors as 3 outdoors, and usually a little bit lower 4 indoors than outdoors. 5 Did that answer your question, 6 ma'am? 7 Q. What I'm -- Let's bring this 8 conversation back to causation. If you 9 don't -- If you just see what you claim is 10 mold, according to the literature that you 11 cited, any visible mold outside of the 12 small amount you might see in a shower, is 13 considered or termed mold contamination. 14 How do you rule out other causes of 15 potential mold exposure to an individual 16 that is claiming health effects if you 17 don't do any sort of comparison? 18 A. Excellent question. Well, the 19 next step is this, and I'm going to give 20 you another reference. Because, you know, 21 it's one thing for me to say as an expert, 22 but another thing because you have experts 23 on the other side saying something 24 different. So how does a finder of fact, 25 how does the judge know what's so? So it's</p>	<p style="text-align: right;">Page 33</p> <p>1 some other cause. Well, first off, most 2 doctors are not trained to determine 3 causation of disease. Most doctors are 4 trained to diagnose a disease and treat it, 5 but not to figure out what it is being 6 caused from -- by from some type of 7 occupational and environmental exposure 8 circumstance. There are only three 9 specialties that are specifically trained, 10 and in the normal course of their practice 11 determine causation of disease due to an 12 occupational or environmental exposure 13 circumstance. All three of these 14 specialties are under the American Board of 15 Preventative Medicine. And, by the way, 16 these are the only three specialties to my 17 knowledge that a doctor requires an 18 additional degree beyond a medical degree, 19 M.D., or D.O., in order to sit for the 20 boards. Because you have to have 21 additional training and education beyond 22 what they teach you in medical school to 23 sort out causation of disease due to an 24 occupational and environmental exposure 25 that they don't teach you in medical</p>

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1 school. And that degree is a Master of
2 Public Health, where you get epidemiology,
3 biostatistics, toxicology, learn a little
4 bit about industrial hygiene, the tools
5 that a doctor needs in order to sort out
6 causation.

7 Well, those three specialties,
8 first off, are aerospace medicine. Those
9 are the NASA doctors. The NASA doctors
10 have to figure out if there's something
11 about the design of a high-flying aircraft
12 or spacecraft that is causing somebody to
13 become ill --

14 Q. Excuse me. I don't mean to
15 interrupt you. But we're getting pretty
16 far afield of my question --

17 A. No, no, no --

18 Q. -- so if you could get to the
19 point, please.

20 A. No, no, no. Ma'am, once I
21 start answering, you got to let me finish
22 answering.

23 Q. You can finish answering. This
24 isn't -- I'm going to have to do additional
25 deposition -- I mean I'm going to have to

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1 reason an aerospace medicine doctor has to
2 be able to sort out causation of disease
3 from an occupational or environmental
4 exposure perspective, and that's why they
5 need a Master of Public Health for the
6 degree.

7 The next specialty is
8 occupational medicine. Those are the guys
9 that are the medical directors of major
10 industrial corporations, or they're the
11 better educated plant doctors. Somebody
12 can come in to the plant physician and say,
13 gee whiz, I have symptoms of shortness of
14 breath, cough, what have you. And a lot of
15 doctors can diagnose asthma and treat
16 asthma, but not many doctors can figure out
17 the cause of that asthma. And it's
18 important for the occupational medicine
19 doctor to know the cause. So, for that
20 reason, the occupational -- because the
21 cause might be the new chemical being used
22 on line five of the plant. And if that's
23 the case, this one individual is the tip of
24 the iceberg of an epidemic of asthma in the
25 plant. So that occupational medicine

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1 ask the judge for more time if we can't get
2 this done in the three hours that we've
3 agreed to.

4 A. Ma'am, I just -- Once I start
5 answering, I have to finish, because I have
6 to keep a record. So you're the master of
7 your questions. I'm the master of my
8 answers. So let me continue.

9 So the aerospace medicine, and
10 this is -- because your question is a
11 complicated question. It is not a simple
12 yes or no. So let me finish, and you will
13 learn something.

14 Aerospace medicine doctors have
15 to figure out there's something about the
16 design of a high -- that's causing the
17 interior of a high-flying aircraft or
18 spacecraft to get somebody sick. And it's
19 an expensive matter. Because if there is,
20 Boeing, which is right down the street, or
21 North American Rockwell has to redesign
22 that spacecraft or aircraft, and it's going
23 to cost hundreds of millions or billions of
24 dollars. So we want a doctor that actually
25 knows what he's doing. So it's for that

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1 doctor has to be trained and in the normal
2 course of the practice sort out causation
3 of disease due to an occupational or
4 environmental exposure perspective. And,
5 for that reason, an occupational medicine
6 doctor has to have a Master of Public
7 Health to sit for the boards.

8 The third specialty is public
9 health and general preventative medicine.
10 Those are -- That's the epidemiological and
11 biostatistical specialty within medicine.
12 Those are the CDC hot zone doctors or the
13 medical directors of a major city or state
14 health department. And they have to figure
15 out causation of disease because Patient A
16 may have diarrhea. Is it due to the person
17 having flu, or did they eat at a dirty
18 restaurant? So a public health and general
19 preventative medicine doctor has to be able
20 to sort out causation.

21 So that's -- Those three
22 specialties -- By the way, I'm board
23 certified in two of those, occupational
24 medicine and public health and general
25 preventative medicine. Those two

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1 specialties -- pardon me -- those three
 2 specialties, two of which I'm boarded in,
 3 then what they do is they do something
 4 different than the average physician. Most
 5 doctors are trained to do a differential
 6 diagnosis. That is, person has symptoms:
 7 Sinusitis, allergic rhinitis, shortness of
 8 breath. Differential diagnosis, what could
 9 be causing this? A number of different
 10 disease processes, but they rule out the
 11 different disease processes and they come
 12 to the proper diagnosis such as, in this
 13 case with Mr. Ralph Simon, allergic
 14 disease. Some allergic exposure is causing
 15 his problems. Many doctors, many -- many
 16 doctors are trained to do a differential
 17 diagnosis. However, not many doctors are
 18 trained to do a differential diagnosis of
 19 etiology; that is, what are the possible
 20 causes from an occupational and
 21 environmental medicine perspective? And,
 22 by the way, Reference Manual of Scientific
 23 Evidence, Third Edition, gets into this
 24 around Page 689 of that treatise. And what
 25 do you do? Well, you take the history from

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1 the individual, you see what type of
 2 exposures the individual had, when was the
 3 onset of the disease process, what may have
 4 caused the disease process to get better or
 5 resolve? And you consider all the
 6 plausible causes for the person's problem,
 7 and then you exclude, through a process of
 8 elimination, those that would not apply.
 9 And then what is left is the -- is the
 10 answer to the differential diagnosis of
 11 etiology that is the cause of the person's
 12 problems.
 13 Q. Is that what you -- the process
 14 you went through with Mr. Simon?
 15 A. Yes.
 16 Q. How did you rule out -- Let me
 17 back up. What do you do when -- Strike
 18 that.
 19 So part of your analysis must
 20 necessarily rely on the history that the
 21 patient gives you; isn't that right?
 22 A. Yes. But not -- But not
 23 solely. I --
 24 Q. Part of it --
 25 A. Part of it. Part of it.

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1 Q. -- was the question.
 2 And what do you do when the
 3 patient doesn't give you an accurate
 4 history?
 5 A. Well --
 6 Q. Let me ask you a different
 7 question.
 8 Would it affect your diagnosis
 9 if the patient does not give you an
 10 accurate history?
 11 A. In this case, I don't think
 12 there's any question about that. Because I
 13 have medical records that corroborate the
 14 history that he provided to me. So medical
 15 records formulated in the course of his
 16 treatment years and years and years before
 17 he ever thought about a possible lawsuit
 18 against Select Comfort. So the history
 19 that he provided was consistent with his
 20 medical records that corroborate his
 21 history. I can point some of those out to
 22 you, if you wish.
 23 Q. Mr. Simon told you that about
 24 three or four years after buying the Select
 25 Comfort bed he began suffering from a host

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1 of maladies that he now attributes to the
 2 Sleep Number bed?
 3 A. That is in my report. Yes. It
 4 says about three or four years after buying
 5 the bed, Mr. Simon began suffering
 6 recurrent sinusitis, ringing in the ears, a
 7 sensation of pressure in the bilateral
 8 ears, dry and burning eyes, and skin
 9 irritation.
 10 Q. On what date did you first meet
 11 Mr. Simon?
 12 A. On the date of my report, which
 13 I believe is June the 4th, 2015.
 14 Q. You also note in here that
 15 Mr. Simon denies any allergies?
 16 A. That's his statement that
 17 denies allergy, yes.
 18 Q. Okay. So he reported to you
 19 that he has no allergies?
 20 A. That's what he says. That is a
 21 layman telling me -- answering my question
 22 concerning allergies. But that's what he
 23 said. Now, I don't see any indication that
 24 that's any sign of a lack of truthfulness
 25 on his part. That's his perception as a

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1 layman.

2 Q. So whether or not he truly has
3 allergies, his perception as a layman is
4 that he does not have allergies?

5 A. Yeah. Because we know he does
6 have allergies because he's allergic to
7 mold, right? Because -- And that's the
8 whole basis of this thing. So his
9 statement of allergies is something that he
10 doesn't feel that he is, in general, an
11 allergic person. It's not something that
12 he feels is part of his general state of
13 health. But we know that he is allergic to
14 mold, because that's the reason why he had
15 the adverse health consequences that led to
16 this issue.

17 Q. And we know that he's allergic
18 to mold because Dr. Wedner tested him?

19 A. No. We know he's allergic
20 to -- well, Dr. -- We know he's allergic to
21 mold based upon the temporal onset of his
22 symptomatology, testing confirming that his
23 bed was contaminated with mold, and
24 resolution of his symptoms that would be
25 related to the allergic manifestation of

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1 building-related disease, doesn't do it
2 based upon allergy testing. However, you
3 know, give Dr. Wedner my regards for
4 thinking -- thanking him for confirming
5 that he is, in fact, allergic to mold with
6 his testing. Because he is -- That's
7 consistent with my finding and my analysis.

8 Q. Are you qualified to read the
9 skin chart that was prepared by
10 Dr. Wedner's office?

11 A. Hand it to me. I'll tell you.

12 Q. It's -- This is my copy, and I
13 don't --

14 A. I won't make any marks on it,
15 and I'll give it back to you.

16 Q. And I don't know that I brought
17 extras. Do you have it in your file? Did
18 you review it?

19 A. I don't know offhand. I'd have
20 to look. You're interested in making sure
21 this flows quickly, so I want to help you
22 do that.

23 So I'm looking at this.

24 MR. CORWIN: For the record, she
25 handed the witness, I'll help you out a

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1 mold after he discovered the mold
2 contamination and no longer was sleeping on
3 a moldy bed. However, Dr. Wedner, I
4 believe, moved forward and also did mold
5 testing that did confirm that he is
6 allergic to mold in addition.

7 Q. Did you review the skin test
8 chart that Dr. Wedner's office did?

9 A. I don't recall when I saw that.
10 I do recall having seen such a chart. I
11 don't recall when I saw that, whether I saw
12 that at the time I wrote up this report or
13 not, and it isn't necessary. I was able to
14 make the analysis as an occupational
15 medicine doctor in the manner that I
16 described. Allergy testing isn't necessary
17 because you could test -- for example,
18 somebody could come back with -- that was
19 negative to mold testing and somebody --
20 so, what, he's not allergic to mold. No,
21 he's not allergic to one or ten or 20 of
22 the 100,000 molds. So that's not -- that's
23 why occupational medicine doctor,
24 particularly one that's trained to deal and
25 does have experience dealing with

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1 little bit, handed the witness the skin
2 test results from Dr. Wedner's clinic.
3 Dr. Wedner did not perform these tests.

4 THE WITNESS: And, well, the
5 first question is, there's some notation
6 here that I've seen skin testing many
7 times. Usually what happens, they'll make
8 little hash marks. Like if there's --
9 Somebody is not reacting, they'll be blank.
10 And then if somebody has a mild reaction,
11 they'll put one hash mark down. And then
12 if they -- if it's more extreme, they'll
13 put two, and then it'll go on. Or maybe
14 they have a bunch of -- three or four hash
15 marks and they have one through it. That's
16 usually how the mold testing that I've
17 seen, and I've seen these, is recorded in
18 their little handwritten notes. And then
19 what they do is then they'll say based
20 upon, because they did the testing or their
21 technician usually did the testing, that
22 they found that the individual had a skin
23 reaction to the mold.

24 Now, here looking at this little
25 testing note, they'll have different

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<p>1 numbers. Like maple, red maple, there's a</p> <p>2 one. Oak mix, two. Somebody wrote Bermuda</p> <p>3 grass, three. Rag weed mix, four;</p> <p>4 Alternaria, which is mold, is a mold.</p> <p>5 Again, let's see, there's panel. Panel 4</p> <p>6 mold, okay. There's Panel 5 mold two.</p> <p>7 Then there's Panel 6. These are -- There</p> <p>8 are three panels for mold that have in each</p> <p>9 panel about eight. So --</p> <p>10 BY MS. FISHER:</p> <p>11 Q. So --</p> <p>12 A. Let me finish, ma'am. So we</p> <p>13 have maybe about less than 24 molds, about</p> <p>14 24 molds out of the 100,000 molds. And on</p> <p>15 this one they say Alternaria, 5;</p> <p>16 aspergillins, 6; fumigatus, 7;</p> <p>17 cladosporium. Cladosporium is the one</p> <p>18 we're concerned about as far as testing</p> <p>19 that was shown in this mattress, 8.</p> <p>20 Fusarium, 9. So that's an indication to me</p> <p>21 that with this notation that the skin</p> <p>22 reactions were more extreme. Two more</p> <p>23 extreme than one, three more extreme than</p> <p>24 two, four more extreme than three, five</p> <p>25 more extreme than four.</p>	<p>1 having what's considered an allergic</p> <p>2 reaction, did you do anything to rule out</p> <p>3 symptoms related to allergies to other</p> <p>4 substances besides mold?</p> <p>5 A. Yes.</p> <p>6 Q. What did do you?</p> <p>7 A. The history from him and review</p> <p>8 of the records. He was in -- Well, in his</p> <p>9 normal state of health as it would relate</p> <p>10 to any allergic manifestation of disease</p> <p>11 until first record of this. Let me back up</p> <p>12 for a second.</p> <p>13 We have Dr. Spiro's records. I</p> <p>14 believe it's Thomas Spiro, who was his</p> <p>15 internal medicine doctor. And I, in</p> <p>16 addition to being board certified in</p> <p>17 occupational medicine and public health and</p> <p>18 general preventative medicine, I'm also an</p> <p>19 internal medicine doctor.</p> <p>20 And I have a note from</p> <p>21 Dr. Spiro from July 16, 1999, that in the</p> <p>22 systematic review, in essence, I'm not</p> <p>23 seeing anything here that has to do with</p> <p>24 any indication of sinusitis, skin rash,</p> <p>25 rhinitis, or shortness of breath or cough.</p>
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<p>1 So that's how I would interpret</p> <p>2 this from looking at the chicken scratch on</p> <p>3 that report.</p> <p>4 Q. Okay. So did you review at one</p> <p>5 point Dr. Wedner's report in which he</p> <p>6 listed out the items that Mr. Simon was</p> <p>7 sensitized to?</p> <p>8 A. I did read his -- I did read</p> <p>9 his report. I don't have -- I think it was</p> <p>10 a report, and then there was a rebuttal</p> <p>11 report to my report. I don't have a</p> <p>12 photographic review of it. If you want to</p> <p>13 draw my attention to the report and have me</p> <p>14 comment upon it, you have to show it to me</p> <p>15 again and I'll look at it again.</p> <p>16 Q. Well, let me just -- I'll just</p> <p>17 refresh your memory that the report</p> <p>18 indicated that Mr. Simon was a highly</p> <p>19 atopic individual allergic, or at least</p> <p>20 sensitized, to multiple different things.</p> <p>21 Do you recall that?</p> <p>22 A. I won't differ with your</p> <p>23 assertion that that's what it says at this</p> <p>24 moment.</p> <p>25 Q. With respect to Mr. Simon</p>	<p>1 No phlegm production, night sweats,</p> <p>2 hemoptysis, or cough. No pain or</p> <p>3 inflammation of the eyes or swelling of the</p> <p>4 eyelids. Ears, no ringing in the ears or</p> <p>5 discharge from the ear canal. Denies</p> <p>6 history of headache or trauma to the head.</p> <p>7 No history of dyspnea. That's shortness of</p> <p>8 breath on exertion. And some history of</p> <p>9 palpitations.</p> <p>10 So from an allergic standpoint,</p> <p>11 his allergic manifestations of disease,</p> <p>12 July 16, 1999, he's fine.</p> <p>13 By the way, long before he's</p> <p>14 really -- I think that at the time of</p> <p>15 either before or shortly after he bought</p> <p>16 the Select Care bed.</p> <p>17 Q. In order to make --</p> <p>18 A. Let me finish, ma'am.</p> <p>19 Then we have a history, a note,</p> <p>20 from Dr. Spiro, October the 8th, 2002,</p> <p>21 where Mr. Ralph Simon presents with --</p> <p>22 presents for physical exam. Patient today</p> <p>23 complains of nasal stuffiness and shortness</p> <p>24 of breath at night, at night is when he's</p> <p>25 having it. And then the records go on</p>

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<p>1 where he's having rhinitis and the like. 2 So we have documentation that he was not 3 having these allergic problems before the 4 issue with the bed. They developed. And 5 then they resolved after he had 6 discovered -- largely resolved, not 7 completely resolved, after he discovered 8 the mold contamination of his bed, and then 9 stopped sleeping on the mold-contaminated 10 bed. So that allows me to have ruled out 11 some other allergic manifestation as the 12 cause of his problems. Why? Well, if he's 13 atopic, he's probably atopic his entire 14 life. When he's living in St. Louis, if he 15 has problems with cladosporium or mold in 16 the air, he's been living with that for 17 years. And he's still living in that 18 environment in St. Louis, the general air 19 environment. It went away. I'm not aware 20 of any assertion that somehow he had some 21 change in his diet that was consistent and 22 accordant with that time duration of his 23 symptomatology with the bed. I'm not aware 24 of any other exposure circumstance that 25 matches the temporal sequence of his</p>	<p>1 Q. What facts in the record are 2 you relying on to show you that there was 3 mold in the bed in 2002? 4 A. First off, there was no testing 5 in 2002 because he didn't know about it. 6 That's part of the problem with this whole 7 thing. We have the fact that he bought the 8 bed some period of time beforehand, I think 9 1999. That would have given ample time for 10 mold to have developed in the bed due to 11 the design defect of Select Comfort, that 12 specifically the impermeable barrier that 13 would lead to accumulation of liquid water 14 and mold growth. And then we have the 15 later discovery of the mold, I think, 16 sometime in 2012. So the deductive logic 17 analysis is that there was mold 18 contamination there during the relevant 19 time period. Because it would have given 20 enough time for mold to have developed, and 21 there's no fact scenario that I'm aware of 22 that would say that the mold contamination 23 that was discovered in around the 2012/2013 24 time period suddenly, acutely developed 25 because there was some water intrusion into</p>
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<p>1 symptomatology other than the bed. So that 2 light leads me to the recognized 3 methodology utilized by occupational 4 medicine doctors as enumerated in the 5 Reference Manual of Scientific Evidence, 6 Third Edition, to say, yes, the cause was 7 the bed. 8 Q. What did you do to rule out 9 dust mites? 10 A. Dust mites would have been part 11 of his environment before the bed. I mean 12 he's been sleeping on beds. There's dust 13 mites in beds. There's dust mites in beds 14 after the fact. So how did the rule change 15 relating to dust mites before and after the 16 time duration that he's sleeping on this 17 moldy bed from Select Care. It's just -- 18 MR. CORWIN: Comfort. 19 THE WITNESS: Select Comfort. 20 That's an exposure that he had before, 21 during, and after. But his symptomatology 22 matches his duration of sleeping on the 23 moldy bed. 24 25 BY MS. FISHER:</p>	<p>1 the home or water intrusion into the 2 mattress. There's -- I'm not aware of any 3 fact scenario consistent with that. 4 Q. So your opinion is based, at 5 least in part, on an assumption of mold in 6 the mattress in 2002? 7 A. I wouldn't say an assumption of 8 mold in the mattress. It's based upon the 9 facts in this matter. There was mold 10 contamination found documented when he 11 discovered the mold. He had it -- It was 12 tested. It was contaminated with 13 cladosporium. And he was sleeping on the 14 mattress. The mattress has an impermeable 15 barrier in the form of its bladder, air 16 bladder, that led mold contamination to 17 happen is what I, given my expertise, would 18 expect to happen, and would give enough 19 time for that to happen. 20 And, by the way, when I talk 21 about that air bladder happening, I'm going 22 to also, so that you're not surprised at 23 trial, I'm also a biomedical engineer, 24 besides being a physician. And biomedical 25 engineering has to do -- part of it would</p>

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<p>1 have to do with design of medical 2 equipment, including -- and also beds. And 3 I am more familiar with beds than most 4 physicians. Because I have, through my 5 career, been called upon to deal with the 6 care of catastrophic injury patients, 7 quadriplegics that would be susceptible to 8 bed sores. So I'm familiar -- I'm more 9 familiar than the average physician with 10 beds, the properties of beds, and, 11 particularly, the properties of beds as a 12 biomedical engineer. That, in addition as 13 an industrial hygienist, I know the 14 circumstances that would lead to mold 15 accumulation due to vapor intrusions. In 16 this case, the vapor intrusion was 17 perspiration, vapor arising from his bed, 18 from his body, lying upon his bed 19 permeating through the sheets, permeating 20 down into the padding of the bed, and then 21 hitting an impermeable barrier, the bladder 22 of the Select Comfort bed, forming liquid 23 water and developing mold. That is the 24 scenario that would happen in a building if 25 you're in an area that is a warm area where</p>	<p>1 sole expert testifying upon that. And it 2 may not -- I may not be called upon to 3 testify to that. That will be Mr. Corwin's 4 decision. But I do believe that I am 5 qualified as a graduate biomedical engineer 6 and a physician, along with my other 7 expertise, to comment upon the design 8 defect of the bed, yes. 9 Q. You mentioned that it would 10 give ample time from the purchase of -- 11 Mr. Simon's purchase of the bed several 12 years later for mold to have grown. How 13 long does it take mold to start growing? 14 A. Mold can start growing very 15 rapidly, within a matter of -- if you have 16 the right circumstances, within a matter of 17 a couple days. 18 Q. When you locate mold, is it 19 possible for you to determine how long mold 20 has been there? 21 A. If I have sufficient additional 22 information such as I have in this case, 23 yes. 24 Q. Do you know the date at 25 which -- when the foam padding on</p>
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<p>1 individuals have air conditioning, where 2 you have vapor intrusions coming in through 3 walls. Because, you know, brick walls, 4 this building, brick still has vapor 5 intrusions coming in through the wall. 6 Brick and mortar doesn't keep water from 7 going through walls. And then the water 8 will follow its radiant down until it hits 9 an impermeable barrier. And that's why 10 you're supposed to be careful and not put 11 vinyl wallpaper upon the interior walls of 12 buildings that are cold in a warm 13 environment. And the reference to that 14 that's, that supports my assertion is out 15 of Bioaerosols: Assessment and Control, 16 10.4.3.2, Condensation Control in Hot and 17 Humid Climates. 18 Q. Are you intending to opine on 19 the defective nature of the bed at trial? 20 A. I'm intending to opine to all 21 my relevant areas of expertise if called 22 upon to do that. That would include the 23 defect of the bed, because I am qualified 24 as a biomedical engineer, I believe, to 25 testify to that. Now, I may not be the</p>	<p>1 Mr. Simon's bed was tested? 2 A. I don't know as I'm sitting 3 here at the moment. I don't have these 4 records memorized. I mean so if you're 5 asking me the specific date, no, not at 6 this moment. If I looked through records 7 and if you want me to take the time to do 8 that, I can start trying to look through 9 records to try to find that. 10 Q. It's not -- 11 A. But I don't have that 12 memorized, no. 13 Q. It's not necessary. If mold 14 was, indeed, tested and found, at least 15 according to Ms. Duncan on a bed four 16 months after Mr. Simon ceased using the 17 bed, isn't it true that all that test shows 18 is that mold was present on the bed on the 19 day of the test? 20 A. No. 21 Q. That is not what that test 22 shows? 23 A. I don't think so. The test is 24 a snapshot, but the test is not the void or 25 absent of the history and information. So</p>

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<p style="text-align: right;">Page 58</p> <p>1 I believe I have sufficient information to</p> <p>2 say that that mold developed over time, and</p> <p>3 that his symptomatology where he -- where</p> <p>4 there's a medical record indicating his</p> <p>5 seeking medical attention for a disease,</p> <p>6 allergic disease, mediated due to his mold</p> <p>7 exposure in the bed, that he sought medical</p> <p>8 attention on October the 8th, 2002.</p> <p>9 Q. Do you have any idea how the --</p> <p>10 how the foam that was in the bed was stored</p> <p>11 in the intervening time period between</p> <p>12 Mr. Simon's alleged discovery and the date</p> <p>13 that it was tested?</p> <p>14 A. I have no indication that it</p> <p>15 was stored in a scenario or circumstance</p> <p>16 that would lead to any spoilage of the --</p> <p>17 of the sample. If you have some</p> <p>18 information that you think it was somehow</p> <p>19 spoiled, let me know, and I may alter my</p> <p>20 opinion. But I'm -- but I'm operating</p> <p>21 under the understanding that it was stored</p> <p>22 in a manner that the visible mold</p> <p>23 contamination that he saw when he opened up</p> <p>24 the bed and found that hidden defect is</p> <p>25 representative of the visible mold</p>	<p style="text-align: right;">Page 60</p> <p>1 upon somebody to do the testing which, in</p> <p>2 fact, confirmed that it's mold. So I see</p> <p>3 nothing about Mr. Simon that would make him</p> <p>4 any less qualified as a layman to look at a</p> <p>5 circumstance and have strong suspicion that</p> <p>6 it's mold. And I believe that's what</p> <p>7 happened in this matter. And then it was,</p> <p>8 in fact, confirmed that it was mold based</p> <p>9 upon the testing.</p> <p>10 Q. Would you agree with me,</p> <p>11 though, that the testing to be the most</p> <p>12 accurate should have been confirmed</p> <p>13 immediately? Should have been performed so</p> <p>14 that mold could have been confirmed</p> <p>15 immediately on discovery?</p> <p>16 A. No, no. I mean are you saying</p> <p>17 that this is some type of -- there's</p> <p>18 something about mold that if you don't</p> <p>19 capture it at that moment that the results</p> <p>20 are going to be different? Now that's true</p> <p>21 with different types of toxin exposures,</p> <p>22 like carbon monoxide. If you went into --</p> <p>23 By the way, I am a toxicologist. It's not</p> <p>24 just me saying that. If you go to the</p> <p>25 Reference Manual of Scientific Evidence,</p>
<p style="text-align: right;">Page 59</p> <p>1 contamination that was confirmed with</p> <p>2 testing by Ms. Duncan four months later.</p> <p>3 But if there's something that</p> <p>4 you think would lead -- that you think it</p> <p>5 was somehow spoiled, led to mold growth in</p> <p>6 the interval, let me know. I'm not aware</p> <p>7 of any -- of any unique circumstance, but</p> <p>8 perhaps you are.</p> <p>9 Q. If, indeed, it -- If, indeed,</p> <p>10 there was a circumstance that could have</p> <p>11 led to mold growth in the intervening</p> <p>12 period, would that change your opinion?</p> <p>13 A. Tell me what the circumstance</p> <p>14 is, otherwise you cause me to speculate.</p> <p>15 It's caused -- Your asked question calls</p> <p>16 for speculation.</p> <p>17 Q. Let me ask you a different</p> <p>18 question.</p> <p>19 Are you of the opinion that</p> <p>20 Mr. Simon is sufficiently qualified to</p> <p>21 identify mold contamination visually?</p> <p>22 A. I think people in general have</p> <p>23 seen mold. I don't think it's unique for</p> <p>24 people to have looked at and see this looks</p> <p>25 like mold, and then for him to have called</p>	<p style="text-align: right;">Page 61</p> <p>1 Third Edition, on about Page 675, I qualify</p> <p>2 in a number of points to be a toxicologist,</p> <p>3 and I deal with toxicologic issues very</p> <p>4 commonly.</p> <p>5 For example, if somebody has</p> <p>6 carbon monoxide exposure and they get</p> <p>7 exposed to carbon monoxide, if they go to</p> <p>8 the hospital very rapidly, then a</p> <p>9 carboxyhemoglobin level can be drawn, and</p> <p>10 that would document the level of</p> <p>11 carboxyhemoglobin close to the time of the</p> <p>12 exposure. If you wait a day, even a number</p> <p>13 of hours that -- you're going to lose that</p> <p>14 information. That's not the case with</p> <p>15 mold.</p> <p>16 So, in this circumstance, I --</p> <p>17 Unless you have some unique -- if you have</p> <p>18 some circumstance that would lead to</p> <p>19 spoilage, the fact that the mold is sitting</p> <p>20 there four months later and tested after</p> <p>21 the initial discovery, that doesn't</p> <p>22 question me -- lead me to question the</p> <p>23 results. And, in fact, that's very</p> <p>24 commonly the case in buildings. Somebody</p> <p>25 sees mold and it's not tested until four</p>

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<p>1 months later, that, given the circumstances 2 and findings, doesn't say, oh, that mold 3 grew in the meantime. It could have, if 4 you can give indication that it would have. 5 But the fact that the testing is done four 6 months later doesn't -- doesn't nullify the 7 analysis. If somebody is saying something 8 different, I believe that they are not 9 making a statement that would be generally 10 accepted in the relevant industrial hygiene 11 and medical community. And I would say 12 that they should come up with some 13 peer-reviewed literature that would 14 corroborate their statements. Because I 15 think it would be junk science.</p> <p>16 Q. You just did confirm, though, 17 that mold can grow within a couple days?</p> <p>18 A. I did. But tell me the 19 circumstances that you think happened here 20 that caused this mold to grow in the 21 pattern that is found on his bed consistent 22 with perspiration coming in from the body. 23 In fact, maybe an analogy can be made, it 24 looks almost a little bit like the Shroud 25 of Turin. The mold is where you would</p>	<p>1 knowing about the mold. Because I believe 2 in this circumstance his doctors did not 3 know, nor should they have been aware, of 4 the mold given the circumstances because it 5 was a hidden defect in the bed.</p> <p>6 Q. You know what, I'm going to 7 backtrack a little bit and take care of 8 some generalities before we run out of 9 time. When were you first contacted for 10 this case?</p> <p>11 A. Yes, ma'am. I don't recall. 12 It was obviously sometime before June the 13 4th, 2015. How long before that, I don't 14 know. I don't think it was years before. 15 Probably a matter of a few months, but I 16 don't have a present recollection.</p> <p>17 Q. Do you recall who contacted 18 you?</p> <p>19 A. I believe Mr. Corwin.</p> <p>20 Q. What was the scope of the 21 request?</p> <p>22 A. Well, I don't have a present, 23 you know, recollection of the request in 24 any detail, but I think he probably told me 25 the fact scenario. And I told them, well,</p>
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<p>1 expect the perspiration to come. Give me 2 the circumstance that you think created 3 that other than the vapor intrusions -- 4 (Interruption in 5 deposition.)</p> <p>6 MR. CORWIN: Is this something 7 you need to take?</p> <p>8 THE WITNESS: No. The vapor 9 intrusions from the -- from somebody 10 sleeping on the bed and having mold 11 accumulate due to the design defect of the 12 bed and the failure of warning -- By the 13 way, I think I have expertise concerning 14 warnings, being an occupational medicine 15 doctor.</p> <p>16 MS. FISHER: No doubt you do.</p> <p>17 THE WITNESS: And industrial 18 hygienist to warn him to be able to look 19 for mold, be concerned about this as a 20 possibility so that he could then inform 21 his doctors -- discover the mold and then 22 inform the doctors that are treating him 23 for his symptomatology so that they would 24 be aware and avoid adverse health effects 25 that happen to him due to the doctors not</p>	<p>1 listen, these are -- This is my area of 2 expertise, these are my -- the areas that I 3 can address. These are my charges. 4 Obviously I don't know what my opinion is 5 going to be until I've done my analysis. I 6 told him that my charge is \$30,000 for the 7 review of the records, preparation, really 8 everything other than travel time, waiting 9 around time, and testimony time. But that, 10 you know, I don't know what my opinion is 11 until I see it. And if my opinion is in 12 favor of you and you wish me to write the 13 report, I keep the \$30,000. If my opinion 14 is not in favor of your situation, I will 15 give back the \$30,000. That's, in essence, 16 what I believe I told him. And then he 17 contacted me some period thereafter to say, 18 yes, I wish you to go forward with the 19 process, sent me -- I believe he sent me 20 records to look at initially. And then I 21 said, well, this looks like I may be able 22 to be favorable, and then I did my 23 examination of Mr. Simon and formulated my 24 opinion and then report.</p> <p>25 Q. I'm going to hand you a copy of</p>

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<p>1 your report in case you don't have it right 2 in front of you. 3 (Document marked as Dr. 4 Chiodo Exhibit No. 2 for 5 identification.) 6 BY MS. FISHER: 7 Q. Is that the report, the initial 8 report, that you wrote in this case? 9 A. It looks like it. Yes, ma'am. 10 Q. Take your time if you need more 11 time. 12 A. Yeah. I -- It looks like my 13 report. 14 Q. Are all the documents that you 15 reviewed listed under -- on Page 2 under 16 records reviewed? 17 A. As of the date of my report. 18 Not necessarily all the records I 19 subsequently reviewed. 20 Q. Okay. What -- 21 A. What I call the records may be 22 something different than what you're 23 calling the records or Mr. Corwin may call 24 the records. But this is my enumeration of 25 what I call the records as of the date that</p>	<p>1 for -- What was your objection at the first 2 depo we did? Confidential or privileged 3 discussions. Subject to that, you can go 4 ahead and answer. I think it's also vague 5 as called for, but -- 6 THE WITNESS: Yeah. I mean 7 there are my opinions that I have at that 8 time. Whether I'm going to be called upon 9 to render additional opinions within my 10 relevant areas of expertise, I don't know. 11 And there may be opinions that come up due 12 to your questioning, cross-examination at 13 trial that I may not anticipate. So I 14 don't necessarily anticipate all the 15 questions that Mr. Corwin is going to ask 16 me on direct examination that would get 17 into my analysis concerning this 18 circumstance utilizing my areas of 19 expertise. Nor can I say -- So, therefore, 20 the report is not necessarily limited to 21 that. I'm not saying that this is the 22 totality of all possible opinions. I think 23 it is the central focus of my opinions in 24 this matter. But you may also ask me 25 questions on cross-examination that will</p>
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<p>1 I wrote my report. 2 Q. After, subsequent to the time 3 you wrote your report, are there additional 4 records that you've reviewed? 5 A. Yes. 6 Q. Can you -- 7 A. But I don't have an enumeration 8 of those. 9 Q. Can you tell me what they are? 10 A. Well, not with -- I mean I can 11 tell you in general I believe I reviewed 12 the reports from your experts and rebuttal 13 reports. I don't know if I -- I can't 14 recall whether I reviewed deposition 15 testimony or not. Mr. Corwin knows what he 16 sent me, but I don't have an enumeration of 17 that. 18 Q. Did you ever review the 19 deposition testimony of Mr. Ralph Simon? 20 A. I don't recall as I'm sitting 21 here today. 22 Q. Does the report contain all the 23 opinions that you originally were requested 24 to provide an opinion on and testimony on? 25 MR. CORWIN: Objection. Calls</p>	<p>1 elicit answers and opinions that are not 2 enumerated in this report. 3 BY MS. FISHER: 4 Q. So on Page 1 I see your 5 qualifications to opine, and it goes on to 6 Page 2. And I understand that you also a 7 CV which we've got here marked as 8 Exhibit 1. I just want to just make clear 9 a couple things. You don't have any 10 continuing education or you're not board 11 certified in allergy or immunology, 12 correct? 13 A. No. I am board certified in 14 general internal medicine. Allergy and 15 immunology is an internal medicine 16 subspecialty. So I do have training, board 17 certification, recertification, and also 18 additional recertification in general 19 internal medicine that includes allergy and 20 immunology. But I am not board certified 21 in the subspecialty of allergy and 22 immunology. But that's -- But I am not 23 devoid of knowledge and expertise 24 concerning allergy and immunology. And 25 that, of course, I have additional</p>

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<p>1 expertise being board certified in 2 occupational medicine. The actual board 3 certification certificate says occupational 4 medicine, and it's typically referred to as 5 occupational environmental medicine which 6 deals with allergic issues in this context 7 with mold. In fact, that's usually the 8 central expert, and also the central 9 clinician sorting out mold exposure issues 10 in this matter, whether or not the disease 11 was caused by a building-related issue. 12 And then also additional expertise as far 13 as epidemiology and biostatistics that 14 would call upon allergic-mediated disease 15 through my board certification in public 16 health and general preventative medicine. 17 And, of course, I'm one of the 18 few physicians, really in the world, that 19 is a certified industrial hygienist. 20 There's 6,600 certified industrial 21 hygienists in the world. Only about 5 to 22 10 of them are physicians, to the best of 23 my knowledge. And I have some stature in 24 that profession in that I'm one of the past 25 presidents of the Michigan Industrial</p>	<p>1 corticosteroid. I believe that not only am 2 I qualified as an internal medicine doctor, 3 because internal medicine doctors are very 4 commonly the type of doctors that would 5 order corticosteroids, including 6 Prednisone, and must know about the 7 toxicity. I am also a toxicologist. 8 Again, if you -- not just a matter of 9 myself proclaiming such. If you go to the 10 Reference Manual of Scientific Evidence, 11 Third Edition, on or about Page 675 I meet 12 the qualifications on at least three points 13 of being a toxicologist. So I am an expert 14 concerning the toxicologic effects of drugs 15 and other substances as they relate to the 16 eye. But I'm not an ophthalmologist. And, 17 likewise, I don't think just because 18 somebody is an ophthalmologist they're 19 necessarily qualified to opine about the 20 toxicologic effects of substances as it may 21 relate to eyes. They're obviously 22 qualified in general about eyes, but not -- 23 that doesn't make them a toxicologist. 24 Q. How about an 25 otorhinolaryngologist. I'm going to</p>
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<p>1 Hygiene Society, which was the first 2 industrial hygiene organization in the 3 country. 4 So I would disagree with your 5 assertion that I don't have knowledge, 6 training, and continuing education 7 concerning allergy and immunology. And, in 8 fact, I happen to have brought along me 9 today, not for this deposition, just 10 because when I'm on the plane I read, the 11 American College of Physicians Medical 12 Knowledge Self-Assessment Program 17. Now 13 this one happens to be on cardiovascular 14 medicine. But one of the monographs on 16, 15 which I completed within the last year or 16 two, was on allergy and immunology. So I 17 keep up on the relevant discipline. 18 Q. Are you trained in any special 19 way in the discipline of ophthalmology? 20 A. I don't consider myself an 21 ophthalmologist, but I am trained 22 concerning toxicologic effects due to 23 substances, including drugs. So as to the 24 issue of cataracts caused by 25 corticosteroids, Prednisone is a</p>	<p>1 butcher it. An ENT? 2 A. ENT. That's good. 3 Q. We'll do that. 4 A. That's good enough. Again, I'm 5 not an ears, nose, and throat doctor, an 6 otorhinolaryngologist. But, again, the 7 issues of the toxicologic effects of 8 substances as it relates to the ears, nose, 9 and throat, as to the allergic consequences 10 of exposures as well within my expertise. 11 That's why there are general internal 12 medicine doctors. General internal 13 medicine is actually a very broad 14 specialty. You have to probably know more 15 and stay current on -- concerning more 16 issues as a general internist than any 17 other specialty. Ophthalmology, you have 18 the benefit that you can just -- entire 19 focus in life can be focus canned just on 20 eyes. As a general internal medicine 21 doctor, you have to know about hearts, you 22 have to know about kidneys, you have to 23 know about lungs, you have to know about 24 ears, nose, and throat. You have to know 25 about dermatology and neurology. It's a</p>

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<p>1 very broad specialty that you have to know</p> <p>2 and be very conversant in broad specialty</p> <p>3 in that you have to have an in-depth</p> <p>4 knowledge, unlike family practice, where it</p> <p>5 is a much more superficial knowledge than a</p> <p>6 board certified general internal medicine</p> <p>7 doctor.</p> <p>8 Q. You are of the opinion that</p> <p>9 Mr. Simon's cataracts are due to</p> <p>10 Prednisone?</p> <p>11 A. Yes, ma'am.</p> <p>12 Q. And you cite a -- You cite a</p> <p>13 study or you cite some literature,</p> <p>14 steroids, including Prednisone, are well</p> <p>15 known to cause cataracts?</p> <p>16 A. Yes.</p> <p>17 Q. Or, actually, that's your</p> <p>18 statement. The literature that you cite is</p> <p>19 Steroid Cataract. Is that the literature</p> <p>20 you're basing your opinion on?</p> <p>21 A. No, not solely. That's</p> <p>22 literature. Also I brought with me today</p> <p>23 the Merck Manual, 19th Edition, copyright</p> <p>24 2011, Page 606 and 607. Cataracts. Talks</p> <p>25 about etiology of cataracts, okay. And it</p>	<p>1 Reduced risk factors such as alcohol,</p> <p>2 tobacco, and corticosteroids and</p> <p>3 controlling blood glucose in diabetes</p> <p>4 delays onset.</p> <p>5 Now, nothing in this treatise</p> <p>6 that I saw said that cataracts, due to</p> <p>7 steroids, are solely postocular lenticular</p> <p>8 cataracts as Dr. Shear asserts. So maybe</p> <p>9 he's confused the initial study that I --</p> <p>10 This is the early study that talked about</p> <p>11 cataracts, mentioned that they were</p> <p>12 posterior subcapsular lens opacities.</p> <p>13 However, to my knowledge, the risk of</p> <p>14 corticosteroids applies in general to</p> <p>15 cataracts.</p> <p>16 Now, if he somehow thinks I'm</p> <p>17 different, I'll let him support his opinion</p> <p>18 with whatever he thinks. But as to my</p> <p>19 opinion, I believe my opinion is supported</p> <p>20 by the literature that I cite. And that in</p> <p>21 light of Dr. Shear's claim, I brought along</p> <p>22 the Merck Manual, 19th edition, and I</p> <p>23 believe that the risk to cataract applies</p> <p>24 not solely to just subcapsular cataracts</p> <p>25 from corticosteroids, but to cataracts in</p>
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<p>1 says etiology, cataracts can occur with</p> <p>2 aging. Other risk factors may include the</p> <p>3 following: Trauma, sometimes causing</p> <p>4 cataracts years later. Smoking, alcohol</p> <p>5 use, exposure to x-rays, heat from infrared</p> <p>6 exposure, systemic disease; e.g., diabetes.</p> <p>7 Uveitis, which is like inflammation of part</p> <p>8 of the eye. Systemic drugs; e.g.,</p> <p>9 corticosteroids, undernutrition, dark eyes,</p> <p>10 possibly chronic ultraviolet exposure.</p> <p>11 Many people have no risk factors other than</p> <p>12 age. Some cataracts are congenital</p> <p>13 associated with numerous syndromes and</p> <p>14 diseases.</p> <p>15 In fact, it continues on. This</p> <p>16 is actually a good couple pages --</p> <p>17 Q. I really don't want you to read</p> <p>18 a couple pages.</p> <p>19 A. No, ma'am. I'm not going to</p> <p>20 read the pages. But I do have to complete</p> <p>21 my answer.</p> <p>22 And then at the bottom of 607,</p> <p>23 prevention. Many ophthalmologists</p> <p>24 recommend ultraviolet-coated eyeglasses or</p> <p>25 sunglasses as a preventive measure.</p>	<p>1 general. That combined with the fact that</p> <p>2 usually cataracts will develop in</p> <p>3 individuals in their 60s or 70s. That's</p> <p>4 when you really start having manifestation.</p> <p>5 And then Mr. Simons developed his cataracts</p> <p>6 at a very young age. That leads me to</p> <p>7 believe that the cataracts were caused by,</p> <p>8 at least in part, by his prescription of</p> <p>9 Prednisone, a corticosteroid, due to the</p> <p>10 lack of knowledge of his physicians that he</p> <p>11 was sleeping on a moldy bed. I'm not</p> <p>12 criticizing his physicians at all. There's</p> <p>13 no criticism on my part of any of his</p> <p>14 physicians, his treating physicians. But</p> <p>15 that his cataracts were caused by, at least</p> <p>16 in part, if not solely, due to Prednisone.</p> <p>17 And, again, I've just provided you the</p> <p>18 literature cite that I believe corroborates</p> <p>19 my opinion.</p> <p>20 Q. So the literature that you</p> <p>21 are -- Do you need to take a break?</p> <p>22 MR. CORWIN: Yeah.</p> <p>23 MS. FISHER: Okay. Can I</p> <p>24 just --</p> <p>25 MR. CORWIN: Finish your</p>

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<p>1 thought.</p> <p>2 MS. FISHER: If the witness can</p> <p>3 keep the answers confined and --</p> <p>4 MR. CORWIN: He's doing the best</p> <p>5 he can. Mr. Carlson, I had similar</p> <p>6 problems with him -- not Carlson.</p> <p>7 Hemmings. But --</p> <p>8 MS. FISHER: So let me just ask</p> <p>9 the next question on this line and then</p> <p>10 we'll take a break.</p> <p>11 MR. CORWIN: Sure. Okay.</p> <p>12 BY MS. FISHER:</p> <p>13 Q. And I'm going to give you -- So</p> <p>14 the question is --</p> <p>15 A. I can't promise a short answer,</p> <p>16 so maybe we should just take a break now.</p> <p>17 Q. The question is you're relying</p> <p>18 on the literature that you cited and the</p> <p>19 book you just read from, and those are your</p> <p>20 sources?</p> <p>21 A. Well, and my knowledge,</p> <p>22 training, and experience. These are just</p> <p>23 corroborating what I know.</p> <p>24 Q. Okay.</p> <p>25 A. I mean Dr. Shear can say he</p>	<p>1 treatise, the Merck Manual, as I'm sitting</p> <p>2 here today because of the assertion brought</p> <p>3 up by Dr. Shear.</p> <p>4 Q. So you don't -- You don't</p> <p>5 disagree with -- You don't agree with the</p> <p>6 assertion in this article, at least, that</p> <p>7 the type of steroids that was seen in the</p> <p>8 study that was referenced in this article</p> <p>9 entitled Steroid Cataract was a posterior</p> <p>10 subcapsular cataract?</p> <p>11 A. Yeah. My understanding from</p> <p>12 briefly looking at this again; again, it's</p> <p>13 been some time since I've reviewed this and</p> <p>14 written my report. So to be quizzed about</p> <p>15 it, I'd have to read it again. However,</p> <p>16 that being said, it's my understanding is</p> <p>17 that from just looking at the beginning of</p> <p>18 it, they found individuals with</p> <p>19 subcapsular -- posterior subcapsular lens</p> <p>20 opacities in 25 steroid-treated group. And</p> <p>21 five in the nonsteroid group. So that this</p> <p>22 is a study that I believe was one of the</p> <p>23 early studies that said, oh, steroids can</p> <p>24 cause cataracts. Now, I think it's a</p> <p>25 misinterpretation to say that, oh, you</p>
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<p>1 knows certain things because he's been an</p> <p>2 ophthalmologist for however long. I know</p> <p>3 certain things based upon my knowledge,</p> <p>4 training, and experience. So the</p> <p>5 literature cites are not the basis of my</p> <p>6 opinion. They corroborate my opinion based</p> <p>7 upon my knowledge, training, and</p> <p>8 experience.</p> <p>9 Q. Why don't we take a break. Go</p> <p>10 off the record.</p> <p>11 (Short break taken.)</p> <p>12 BY MS. FISHER:</p> <p>13 Q. I'm going to have the court*</p> <p>14 reporter mark the next exhibit as</p> <p>15 Exhibit 3.</p> <p>16 (Document marked as Dr.</p> <p>17 Chiodo Exhibit No. 3 for</p> <p>18 identification.)</p> <p>19 BY MS. FISHER:</p> <p>20 Q. This is the article that you</p> <p>21 referenced in your opinion, isn't it?</p> <p>22 A. Yes. Well, that I referenced</p> <p>23 in my report.</p> <p>24 Q. I'm sorry. In your report.</p> <p>25 A. Also reference is another</p>	<p>1 know, only -- steroids only cause posterior</p> <p>2 subcapsular cataracts. No. Steroids are a</p> <p>3 risk for cataracts in general. And</p> <p>4 Dr. Shear's assertion that they're not a --</p> <p>5 that they're not a source of risk for</p> <p>6 development of cataracts in general is</p> <p>7 inconsistent with what I just read to you</p> <p>8 from the Merck Manual. So the --</p> <p>9 Q. So the Merck Manual is your</p> <p>10 reference that steroid-related cataracts go</p> <p>11 beyond and have been found other than in</p> <p>12 posterior subcapsular cataracts?</p> <p>13 A. Yeah. Again, you look at the</p> <p>14 Merck Manual. They talk about the risk of</p> <p>15 cataracts. One of the risk factors for</p> <p>16 cataracts is corticosteroids. That</p> <p>17 includes Prednisone. They don't say one of</p> <p>18 the risk factors for just posterior</p> <p>19 subcapsular cataracts, as Dr. Shear is</p> <p>20 asserting. They say at risk for cataracts.</p> <p>21 Now, I'll leave him to support his opinion</p> <p>22 with literature that says that I'm wrong in</p> <p>23 my opinion and my understanding. I've just</p> <p>24 cited literature that I believe</p> <p>25 corroborates my opinion, okay? If he</p>

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1 thinks I'm wrong, then he can come up with
2 his literature that he thinks supports his
3 assertion that I'm wrong. But I believe
4 this Merck Manual corroborates my assertion
5 and my knowledge based upon my training,
6 education, and experience that
7 corticosteroids, including Prednisone, are
8 a risk factor for cataracts. Cataracts in
9 general, cataracts as they relate to
10 Mr. Simon. But if Dr. Shear thinks that he
11 has some specialized knowledge that he's
12 going to oppose mine, I'll leave him to
13 render his opinion and come up with
14 literature that shows that what he's saying
15 is not just -- is not junk science and meet
16 his Daubert requirements.

17 Q. Would you turn to Page 365 on
18 the article. In the left-hand column about
19 a little more than three-quarters of the
20 way down there's a paragraph that starts,
21 Before Diagnosis.

22 A. Bear with me for a second.
23 Now, by the way, if you want me to refer --
24 Let me put this as a general statement.
25 You're going through and referring me to

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1 have to be considered; e.g., familial,
2 traumatic, complicated, toxic, radiational,
3 and senile. Would you agree with that
4 statement?

5 A. I think I generally agree with
6 the assertion that if you're talking to --
7 as to causation, you need to do a
8 differential diagnosis of etiology. And
9 I'm not aware of any risk factor that would
10 have produced the combination of problems
11 that Mr. Simon has suffered other than his
12 exposure to mold in the form of his bed and
13 his -- and the consequences of that
14 including chronic sinusitis, and his
15 treatment with steroids. So I'm not aware
16 of any combination, any other cause that
17 would explain that combination or
18 presentation on his part.

19 So, yes, I believe that you
20 have to do a differential diagnosis of
21 etiology, and I'm the one that referenced
22 you to the Reference Manual of Scientific
23 Evidence, Third Edition, on or about, I
24 believe it was 6 -- Page 686. So I do, in
25 general, agree with that.

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1 certain lines in this document that I have
2 not read since June the 4th, 2015, the date
3 of my report. Now this is now August the
4 20th, 2015. So you may be cherry-picking
5 sections of that. And I won't -- to quiz
6 me at it or to have me comment upon the
7 implication of any writing upon this, I
8 have to reread the entire document to see
9 if what you're reading is being taken out
10 of context. With that being said, if you
11 want to address my attention to something
12 and see if you correctly read what you're
13 about to read, I'd be happy to do that.
14 But for me to comment and say that that
15 represents the total impact of this paper,
16 let alone the underlying question, I'd have
17 to reread this article. So that being
18 said, I'm at your service.

19 Q. Let me direct your attention to
20 the paragraph that starts before diagnosis.

21 A. Right.

22 Q. Would you just generally agree
23 with the statement that before a diagnosis
24 of steroid cataract can be made, other
25 causes of posterior subcapsular opacities

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1 Q. And you have ruled out
2 hereditary familial cataracts for
3 Mr. Simon?

4 A. I'm not aware that -- I'm not
5 aware, as I say, testimony, as I've said,
6 cause, if not the sole cause. Somebody
7 could have some genetic component that make
8 them particularly susceptible. That
9 doesn't mean that they have a target
10 painted upon them. And that means that
11 cause, if not the sole cause. So one -- It
12 is very rare to have cataracts at a young
13 age -- It's rare to have cataracts at a
14 young age. If you have some information
15 that says otherwise in the case of
16 Mr. Simon, that there's some rare genetic
17 defect that he has that caused him to have
18 early cataracts, fine. Thank you. I'd be
19 interested in hearing that.

20 And then the next question is,
21 okay, fine, so he's -- If that's the case,
22 then he's susceptible to cataracts and then
23 you have another exposure that's going to
24 make him have another risk factor for
25 cataracts. That doesn't nullify the

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1 causation analysis. The only factor that
2 that would include would be caused by, if
3 not solely, by cataracts. And, by the way,
4 that was my testimony. If you go back in
5 my -- to the transcript before you begin
6 asking this line of questioning, I said
7 that I believe that his cataracts were
8 caused by, if not solely caused by,
9 corticosteroids.

10 Q. Are you familiar with the lens
11 opacity grading system -- I'm sorry --
12 classification system.

13 A. Not as I'm sitting here at this
14 moment. I can go back and look that up if
15 that -- if that were germane to this issue,
16 I would be. But I'm -- I'm not aware that
17 it is germane. I know that he has
18 cataracts, he's been diagnosed with
19 cataracts. And what grade he is on
20 cataracts doesn't impact the causal
21 analysis, from my perspective. Maybe
22 Dr. Shear thinks so. And I'll let him
23 explain why he thinks so, if, in fact,
24 that's what he thinks. Because obviously
25 you're not testifying. You have to have

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1 enumerated in the Reference Manual of
2 Scientific Evidence, Third Edition, on or
3 about Page 675.

4 Q. So have you actually seen the
5 evidence that would allow you to determine
6 how large of doses, how many, and for what
7 length of time Mr. Simon actually
8 physically received Prednisone?

9 A. I have his medical records. I
10 reviewed them. I don't have them
11 memorized. If you're asking me to
12 enumerate what doses, when he took or
13 whatever, I can't -- I'd have to go back
14 through it. I'd be happy to do that if you
15 want to start using your remaining
16 deposition time for me to go through that
17 exercise. I can merely state that's my
18 understanding that he had a somewhat
19 prolonged course of steroids due to his
20 manifestation of disease. And, quite
21 frankly, they couldn't figure out what was
22 causing his problem in that it is not
23 necessary in the analysis nor do I believe
24 that it would be generally accepted that I
25 have to know exactly what day he started --

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1 some expert testify. I anticipate he's
2 going to be the expert testifying on the
3 issue. I'll let him explain why the
4 grading of the cataracts would be relevant
5 to his analysis contrary to mine.

6 Q. Did you do any analysis with
7 respect to the dosing of the Prednisone
8 that Mr. Simon received?

9 A. My understanding is he was on
10 Prednisone for some significant period of
11 time. And that there is not -- You know,
12 dose response is a sigmoidal curve
13 typically. Some people can develop an
14 adverse consequence at a low dose, and some
15 people can develop it at a high dose. My
16 understanding that this was not a single
17 one-time dose; that this was somewhat of a
18 chronic medication. If I'm incorrect, let
19 me know. And that consequently there would
20 have been sufficient dose to have caused
21 the adverse effects, dose and duration to
22 cause the adverse effects. And that's me
23 testifying not solely as a physician, but
24 as a physician and a toxicologist as the
25 qualifications of being a toxicologist

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1 Although we can work this out from the
2 records in the exact amount of dose.
3 Because toxicity is a sigmoidal curve.
4 Some people are susceptible at a low level.
5 Some people are susceptible at a high
6 level. It tends to be a sigmoidal curve.
7 And that really doesn't get, in this
8 context, into the causation analysis. It
9 just means if you're claiming that he has
10 some type of hereditary predisposition,
11 that you got the eggshell plaintiff.
12 That's all it means.

13 Q. Let's move to -- Well, I'm
14 sorry. Before I -- Are you aware of
15 Mr. Simon taking Prednisone for any other
16 reason other than what he alleges was
17 mold-related allergies?

18 A. You know, again, you're asking
19 me to go back and through the medical --
20 the question that you want me to go back
21 through the medical records. I'll start
22 leafing through this, these medical
23 records.

24 Q. No. Just as you sit here
25 today, do you recall seeing that for any

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<p>1 other reason?</p> <p>2 A. I, again, I don't have these</p> <p>3 records that are probably the size of a</p> <p>4 fairly good metropolis phonebook memorized.</p> <p>5 If you want me to answer a specific</p> <p>6 question to that issue, I have to go back</p> <p>7 through them. If you want to reference me</p> <p>8 to some issue that you think is relevant,</p> <p>9 then I'm happy to tell you whether I think</p> <p>10 that affects my opinion or not. But I</p> <p>11 don't have that type of recall. You know,</p> <p>12 I am a pretty well-educated guy. People</p> <p>13 think I have a better memory than I have.</p> <p>14 I don't have that type of photographic</p> <p>15 memory.</p> <p>16 Q. All right. Let's move to</p> <p>17 another topic. Let me give you another.</p> <p>18 (Document marked as Dr.</p> <p>19 Chiodo Exhibit No. 4 for</p> <p>20 identification.)</p> <p>21 THE WITNESS: Again, if you're</p> <p>22 going to quiz me about the specifics of it,</p> <p>23 I'd have to reread it. I offered this as</p> <p>24 an assertion that the well-known fact</p> <p>25 among -- that I knew based upon my training</p>	<p>1 corroborate my opinion. Why am I doing</p> <p>2 that? Because it's federal court. It's</p> <p>3 Daubert. If I have to offer an opinion, I,</p> <p>4 just like your experts, are supposed to</p> <p>5 corroborate their opinion with citations</p> <p>6 from the peer-reviewed literature. But I</p> <p>7 don't rely upon this. This is -- I've</p> <p>8 known about the ototoxicity of</p> <p>9 aminoglycosides since sometime in the</p> <p>10 either late 1970s or early '80s when I was</p> <p>11 a medical student.</p> <p>12 Q. And that knowledge was based on</p> <p>13 what you learned in medical school,</p> <p>14 correct?</p> <p>15 A. Medical school, residency. I</p> <p>16 mean it's just -- It's just known.</p> <p>17 Aminoglycosides are ototoxic. If somebody</p> <p>18 is saying something different, then they're</p> <p>19 saying -- then it's -- I think that's</p> <p>20 inconsistent with what would be generally</p> <p>21 accepted. But this article is just an</p> <p>22 article that corroborates that opinion.</p> <p>23 Why do I include it? Daubert. That's</p> <p>24 what's required in federal court.</p> <p>25 Q. Can you direct me to any other</p>
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<p>1 and experience probably going all the way</p> <p>2 back to my days in medical school that</p> <p>3 aminoglycosides are ototoxic. So if you</p> <p>4 want to address me to a specific point in</p> <p>5 this article other than my use of this</p> <p>6 article just corroborating my opinion based</p> <p>7 upon my knowledge, training, and</p> <p>8 experience, then I'd have to reread the</p> <p>9 article to answer, you know, to answer any</p> <p>10 type of quiz.</p> <p>11 Q. The first question is, you</p> <p>12 referenced this article in your opinion,</p> <p>13 correct?</p> <p>14 A. Yes.</p> <p>15 Q. And you rely on this article in</p> <p>16 your opinion, correct?</p> <p>17 A. No, no, no.</p> <p>18 Q. You don't rely on this article</p> <p>19 in your opinion?</p> <p>20 A. Ma'am, my opinion is based upon</p> <p>21 my knowledge, training, and experience. I</p> <p>22 don't rely upon this. I knew this -- I</p> <p>23 knew that aminoglycosides were ototoxic</p> <p>24 back when I was a medical student back in</p> <p>25 the early 1980s. What this article does is</p>	<p>1 peer-reviewed literature?</p> <p>2 A. Okay. I'll get out my iPhone</p> <p>3 and I'll start doing a literature search.</p> <p>4 Q. No. If you know some off the</p> <p>5 top of your head, you can point some out.</p> <p>6 My question about this article is with</p> <p>7 respect to the delivery method and dosage</p> <p>8 of gentamycin. Are you aware of any</p> <p>9 differences in delivery methods and dosage</p> <p>10 of gentamycin which would produce a</p> <p>11 potential ototoxicity result? Or is it any</p> <p>12 drop delivered in any manner?</p> <p>13 A. It depends -- Again, obviously</p> <p>14 you have to have -- the aminoglycoside have</p> <p>15 contact with the relevant neural structures</p> <p>16 within the ear to cause the ototoxicity,</p> <p>17 which is essentially a deafness and also</p> <p>18 tinnitus. So you can have that happen via</p> <p>19 IV infusion, you can have that happen with</p> <p>20 topical application, with absorption, or</p> <p>21 with diffusion. I'm not aware that there's</p> <p>22 a limitation to the method. I'm not aware</p> <p>23 that topical drops do not have ototoxicity.</p> <p>24 That is not my understanding. Now, if</p> <p>25 somebody has a contrary opinion, I'll leave</p>

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1 it to them to explain why and have
2 literature that supports their opinion. I
3 believe that this literature corroborates
4 my opinion.

5 Q. I believe earlier you said you
6 didn't fault any of Mr. Simon's treating
7 physicians?

8 A. I don't fault any of them. I
9 do not.

10 Q. Are you aware that his ENT
11 treating physician was aware of his hearing
12 loss and prescribed the gentamycin anyway?

13 A. Yeah. I'm not -- I'm not
14 faulting him. He was put into a very
15 difficult treatment dilemma that if he had
16 known about the mold contamination of the
17 bed, he would not have been put into that
18 difficult circumstance. You know, drugs
19 are used, some drugs are used even if they
20 are going to cause toxicity, because you
21 have no choice. And I am not faulting the
22 treating otolaryngologist in his clinical
23 decision that, yes, you know, I'd rather
24 not use something that is ototoxic in
25 somebody that has some preexisting hearing

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1 loss, but he's painted into a corner. So
2 I'm not faulting him. Now, if you have
3 somebody, one of your doctors that wants to
4 fault him, that's their business. But I --
5 I am not faulting him. He was put into a
6 difficult diagnostic -- diagnostic and
7 treatment dilemma because of the hidden
8 defect of the Select Comfort bed.

9 Q. Are you aware that he testified
10 in his deposition that he didn't believe
11 that the delivery method and amount that
12 Mr. Ralph Simon received of this particular
13 drug would have any bearing on his hearing
14 at all?

15 A. I understand that. The next
16 question is, is he a toxicologist? Because
17 we're talking about ototoxicity. Toxicity
18 means toxicology. So I'm a toxicologist.
19 He's not. So, you know, he deals with
20 ears, nose, and throat. You would think
21 that an ears, nose, and throat would know
22 everything about ears, nose, and throat,
23 but no. If they're not a toxicologist,
24 then I would say that he's not qualified to
25 give that toxicologic opinion. But I am.

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1 And you don't just have to take my word for
2 it. You can go to the Reference Manual of
3 Scientific Evidence, Third Edition, on or
4 about Page 675. I'm a toxicologist. I'm
5 qualified to talk about toxicity including
6 ototoxicity. He's an ear, nose, and throat
7 doctor. I find no reason to believe that
8 he's anything other than a very fine ears,
9 nose, and throat doctor. But he's not a
10 toxicologist. And I think he's -- if -- I
11 think he's wrong if he's making an
12 assertion on the toxicologic issues other
13 than what I'm saying.

14 Q. How much time did you spend
15 with Mr. Simon when you performed his
16 examination?

17 A. Maybe an hour, hour and a half.
18 I don't have an exact recall.

19 Q. I'm going to hand you a new
20 exhibit that we're going to mark as No. 5.
21 (Document marked as Dr.
22 Chiodo Exhibit No. 5 for
23 identification.)

24 BY MS. FISHER:

25 Q. This is not something I'm

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1 certain you've seen before, so I want to
2 give you some time.

3 A. Okay. Then you want me to read
4 it. I'll read the whole thing. I have to
5 read the whole thing, so that will take
6 some time.

7 Q. My first question is, have you
8 ever seen the article before? Are you
9 familiar with it at all?

10 A. I don't recall. I mean if you
11 want me to comment upon an article that
12 I -- I have to read the -- Obviously I have
13 to read the whole article. And I'll tell
14 you it's going to take --

15 Q. I'm not going to ask you to
16 read the whole article. My first question
17 was are you familiar with it at all?

18 A. I may have heard of it. May
19 not have heard of it.

20 Q. Okay. Are you familiar with
21 the AAAAI?

22 A. American Academy of Allergy and
23 Immunology something. I think it's an
24 organization of allergists and
25 immunologists.

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<p>1 Q. And the journal that this was 2 published in, if you look at Page 2 in the 3 upper left-hand corner, was the Journal of 4 Allergy Clinical Immunology?</p> <p>5 A. I would differ with your 6 assertion. I don't know. It's not a 7 journal I subscribe to. Because I'm 8 internal medicine and occupational medicine 9 and public health and general preventative 10 medicine. But that being said, it's not -- 11 This is not -- This article is not famous 12 to me.</p> <p>13 Q. Okay.</p> <p>14 A. What is famous to me, being an 15 expert in this area, is 16 Bioaerosols: Assessment and Control. 17 That's famous to me. But this article is 18 not famous to me.</p> <p>19 Q. Okay. Do you -- Would you -- 20 And I know, understanding you have not read 21 this, but would you have any reason to 22 believe that this article published in the 23 journal of allergy and clinical immunology 24 is not authoritative? 25 MR. CORWIN: Objection.</p>	<p>1 occupational environmental exposure 2 perspective. And -- But with that said, do 3 you want me to read it? I'll read it.</p> <p>4 Q. I do not want you to read it at 5 this time. I merely wanted to know if 6 you're familiar with the literature coming 7 out of the -- from the allergists and 8 pulmonologists field.</p> <p>9 A. Yeah. I mean allergists and 10 immunologists, in my opinion, is not 11 qualified to render an opinion in this 12 matter because they don't have the 13 requisite training to sort out causation in 14 this type of circumstance, in my opinion. 15 Now -- And I've given you the basis of my 16 opinion, and I've told you that the 17 reason -- that's -- My opinion is 18 corroborated by the fact, to my knowledge, 19 the only three specialties that you have to 20 have a degree beyond a medical degree in 21 order to sit for the boards are the three 22 specialties that are specifically trained 23 to sort out causation of disease and do it 24 as part of their normal practice due to an 25 occupational and environmental exposure,</p>
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<p>1 THE WITNESS: I have to read the 2 article to make any comment upon this. So 3 I'll be happy to read it. It starts on 4 Page 326. It goes all the way to -- 5 actually, it's 333. I'll read it if you 6 wish, and then I can comment. But other 7 than -- until I read it, I obviously can't 8 comment upon an article that I haven't read 9 and that I'll say is not famous to me.</p> <p>10 MS. FISHER: Okay.</p> <p>11 THE WITNESS: It's not -- This 12 is not from occupational medicine doctors. 13 This is not from industrial hygienists. 14 This is from allergists and immunologists. 15 And I have a real question of how an 16 allergist and immunologist would be 17 specifically trained to deal with sorting 18 out causation of disease due to mold 19 exposures. It's not their area. They 20 don't have a master of public health. They 21 don't have training in biostatistics or 22 toxicology or epidemiology. That's why I 23 went into that long discussion about 24 doctors that are specifically trained to 25 sort out causation of disease due to an</p>	<p>1 and that degree is a Master of Public 2 Health. I know that one can become board 3 certified in allergy and immunology without 4 that additional education. I'll let your 5 allergist and immunologist expert explain 6 why he's qualified and I'm not and why his 7 opinion is correct and mine is incorrect.</p> <p>8 But, you know, this paper 9 from -- which I have not read or do not 10 recall reading from this journal is his 11 paper. It's not my paper, and I've 12 provided to you literature cites that I 13 believe corroborate my opinion. And if 14 this is his, I'll let him comment upon 15 that, but it's not mine.</p> <p>16 Q. So is it your testimony that 17 there are two or potentially more vastly 18 differing fields of study when it comes to 19 mold and its relationship to health?</p> <p>20 A. No. It's my testimony that the 21 proper medical specialty to sort out 22 causation in this matter is one of the 23 three preventative medicine specialties; 24 that being aerospace medicine, occupational 25 medicine, or public health and general</p>

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<p>1 preventative medicine. And that is why 2 those three specialties are the, to my 3 knowledge, the only three specialties 4 within medicine that require an additional 5 degree in order to sit for the boards. And 6 that additional degree is a Master of 7 Public Health. I'll let somebody else 8 that's not board certified in that area 9 explain why they're qualified. I don't 10 think, if you're not one of those three 11 specialties, that you're really qualified 12 to sort out causation in this matter. And 13 let some -- Let whatever expert you're 14 going to have testify to what they 15 think the literature supports or doesn't 16 support. I know what I believe the 17 literature supports. And I have provided 18 corroboration of my opinion at every single 19 point with literature. And I believe that 20 if one is going to look a reliable 21 authority, the reliable authority on this 22 matter is the treatise Bioaerosols: 23 Assessment and Control from the American 24 Conference of Governmental Industrial 25 Hygienists.</p>	<p>1 I see you don't have it in front of you, 2 because I'm the one who has it. And we 3 got -- We were talking about the cases -- 4 you had X'd the cases, put an X in pencil 5 next to the cases that involved mold. And 6 we already discussed one of the cases. 7 Bobbie Vocke case. And I want to ask you a 8 quick question. I'm going to go through a 9 couple more. 10 Have you ever had a case that 11 was a product-related case -- Have you ever 12 had a mold case that was a product-related 13 case as opposed to a building case? 14 A. I don't recall one offhand as 15 I'm sitting at this moment. That doesn't 16 mean it isn't the case, but I can't recall 17 one as I'm sitting here at this moment. 18 Q. Okay. 19 A. Obviously sort of an unusual 20 circumstance. 21 Q. I'm looking at a case called 22 He Ma vs. Sigma Management Company in the 23 Superior Court of New Jersey. Is that a 24 case that you remember? 25 A. Yes, ma'am.</p>
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<p>1 Q. After you created your rebuttal 2 report, have you been asked to do any 3 follow-up work? 4 A. You mean as far as additional 5 reports? 6 Q. Yes. 7 A. No. That's my only additional 8 report. 9 Q. Other than testifying, do you 10 intend to do any follow-up work? 11 A. Not as of this point. I may be 12 called upon to review additional records, 13 evidence and testimony. And I will do that 14 if asked to do that by Mr. Corwin. I may 15 be called upon to formulate an additional 16 report or -- an additional report. If I'm 17 asked to do that by Mr. Corwin, I will do 18 that. 19 MS. FISHER: Off the record. 20 21 (Discussion had off the 22 record.) 23 BY MS. FISHER: 24 Q. I want to turn back to where we 25 started here, which is your testimony list.</p>	<p>1 Q. Evidence deposition in 2014? 2 A. Yes, ma'am. 3 Q. Can you briefly tell me what 4 that case was about? 5 A. That was an individual that 6 rented an apartment, and there was mold 7 contamination of the apartment building. 8 And that individual, in my opinion, 9 suffered disease causally connected to the 10 apartment building, allergic disease. I 11 can't recall specifically what in that 12 individual. 13 Q. Okay. The next one I'm looking 14 at is Lori Budrow, who is the wife of 15 Kenneth Budrow who is deceased, versus Oak 16 Spur Hills. And that was in the State of 17 Missouri, the Circuit Court of St. Louis 18 County. Do you recall that? 19 A. Yes, ma'am. 20 Q. Can you please briefly tell me 21 about that case? 22 A. Another apartment building, and 23 there were significant water intrusions 24 into his apartment with mold contamination. 25 He's an individual, my recollection, had</p>

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<p>1 preexisting respiratory disease, I believe, 2 in the form of chronic obstructive 3 pulmonary disease, and then had an episode 4 of respiratory arrest and died. It was my 5 opinion that the respiratory arrest was 6 causally connected to the mold 7 contamination of his apartment.</p> <p>8 Q. The next one I'm looking at in 9 reverse chronological order is Lisa Labrake 10 vs. CEI Michigan, LLC and that was in the 11 state of Michigan. You gave a deposition 12 December 13, 2011. Do you recall that 13 case?</p> <p>14 A. Yes. I -- obviously further 15 back in time, less accurate recall. But I 16 believe that was a workers' compensation 17 case involving individuals that worked at a 18 telephone company, I think it was AT&T, 19 with mold contamination in the building. 20 And disease that, in my opinion, was 21 related to their mold exposure in that 22 particular circumstance. More recall than 23 that, I don't have at this time.</p> <p>24 Q. Okay. And the last one that 25 you've got noted here, at least, is -- And</p>	<p>1 luck would have it, the cases where I 2 actually testified are cases where I was 3 the plaintiff expert. I am currently the 4 expert and have been expert in mold cases 5 where there's mold claims and I have been 6 the defense expert. But based upon my 7 analysis in those cases, the claims were 8 not supported. I'm currently an expert in 9 a mold -- defense expert in a mold case in 10 the area of Rockford, Illinois, where there 11 is a claim on the part of the claimants 12 that a child developed autism due to mold. 13 And based upon my analysis that that is 14 incorrect. So I do expert witness work in 15 the mold -- in mold areas in both behalf of 16 plaintiff and defense if I believe that who 17 is retaining me is correct. If I don't 18 think they're correct, I don't do the work 19 for them.</p> <p>20 So that being said, if you're 21 trying to -- somebody is trying to make an 22 assertion based upon this testimony list 23 I'm only a plaintiff expert in mold cases, 24 that's incorrect. Just luck as it has, 25 those are all cases that -- where there is</p>
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<p>1 I should make clear for the record there is 2 one more that you X'd, but it looks like 3 it's also the same case we talked about 4 with Bobbie Vocke. Looks like you gave two 5 depositions in that case: One in 2011 and 6 one in 2014?</p> <p>7 A. One was a discovery deposition 8 and the other was an evidence deposition.</p> <p>9 Q. Okay. And the last one is Sam 10 Aiello, if I'm pronouncing that correctly?</p> <p>11 A. Yes, ma'am.</p> <p>12 Q. A-I-E-L-L-O, vs. Speedwing 13 Investment Company, State of Michigan. Do 14 you recall that case?</p> <p>15 A. Yes. It was a case involving, 16 again, apartment occupant and disease due 17 to mold with the apartment occupants. More 18 detail I can't recall because it's some 19 time ago.</p> <p>20 Q. Okay. And was your opinion 21 that the occupants had disease related to 22 mold?</p> <p>23 A. Yes.</p> <p>24 Q. Okay.</p> <p>25 A. By the way, just to state, as</p>	<p>1 actually to the point where there was 2 either deposition or evidence or trial 3 testimony, and luck would have it that 4 those are all plaintiff cases.</p> <p>5 Q. Can you direct me to any cases 6 that are not on the list? Because I 7 understand this is -- only goes back four 8 years in which you did give trial testimony 9 or deposition testimony as a defense 10 expert?</p> <p>11 A. I can't. Because that's one of 12 the advantages of having a list. I can go 13 back and look at it. So to ask me what my 14 testimony list says would have been more 15 than four years ago, I don't have that type 16 of recall. And, again, it gets into the 17 same issue. Well, I don't know. Does -- 18 the plaintiffs want the deposition. Maybe 19 where I'm the defense expert they don't 20 need the deposition. I don't know why that 21 would be the case, but I do expert witness 22 work, calling it as I see it. And 23 sometimes plaintiff is right. Sometimes 24 defense is right.</p> <p>25 Q. With respect to mold cases in</p>

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<p>1 general, what's your general opinion? Do 2 you think more of them create health 3 effects to the occupants of the buildings, 4 or more of them do not?</p> <p>5 MR. CORWIN: Objection. Vague. 6 THE WITNESS: Yeah. I mean 7 that's -- That question is not specific 8 enough for me to answer. It depends upon 9 the circumstance. 10 BY MS. FISHER: 11 Q. Do you -- 12 A. Sometimes I'm a plaintiff 13 expert, sometimes a defense expert. It all 14 depends upon the specific circumstances of 15 a particular case. I do believe that you 16 can get sick due mold exposure, okay? But 17 it all has to do with what are the exposure 18 circumstances, what are the claimed 19 illnesses. It'll be -- It's very much 20 dependent upon the particular case. 21 Q. I'm going to hand you another 22 exhibit. 23 (Document marked as Dr. 24 Chiodo Exhibit No. 6 for 25 identification.)</p>	<p>1 pretty well qualified. So I thank them for 2 the compliment. 3 And it was an issue about 4 whether or not there's adverse health 5 effects that people have to worry about 6 about radiation emitted from granite. 7 Because granite can emit radiation. Some 8 granite and some granite countertops can be 9 from areas where there's very high 10 concentrations of radioactive materials. 11 So there can be substantial emission of 12 radiation from granite countertops. And I 13 was asked to comment upon the following: 14 That personal injury lawyers are already 15 advertising on the web for clients who 16 think they may have been injured by 17 countertops. And I said, and I don't think 18 they misquoted me, I think there would be a 19 lot of -- it would be a lot like mold 20 litigation a few years back, where some 21 cases were legitimate and a whole lot are 22 not. And I'm no different. Some mold 23 cases are legitimate. A whole lot are not. 24 Some -- You can sit down and say, well, it 25 depends what you're looking at. Maybe a</p>
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<p>1 BY MS. FISHER: 2 Q. State for the record it's a New 3 York Times article from 2008. Are you 4 familiar with this article? 5 A. Yes, ma'am. I was quoted in 6 it. 7 Q. If you need a second to 8 refamiliarize yourself. 9 A. Well, just point to me where my 10 quote is. 11 Q. It's on the very last page. 12 A. Okay. 13 Q. And there is a quote. And 14 first you should let me know if that is an 15 actual quote. I think you already 16 testified that it is, but let me know if 17 you were somehow misquoted. 18 A. Personal injury lawyers are 19 already -- This is a -- This, by the way, 20 put it in context for somebody reading the 21 transcript, this is a quote from the New 22 York Times. They called me up. I guess 23 that indicates that I'm a pretty 24 well-qualified doctor. New York Times 25 usually calls up guys that they think are</p>	<p>1 lot are legitimate and a whole -- and 2 opposing mold cases, a whole lot of 3 opposition are not legitimate. But, you 4 know, some are -- some are legitimate, some 5 are not. 6 Q. And that's your view? 7 A. That's my view. Tell me the -- 8 Give me the specific case, have me take the 9 time to formulate the opinion on that 10 particular case, and I'll tell you if I 11 think it's legitimate. I'll tell you if I 12 think it's not legitimate. That's why I 13 can be -- you know, some cases I'm the 14 expert for the plaintiffs. Some cases I'm 15 the expert for the defense. 16 Q. Did you ask in this particular 17 case for any particular materials when you 18 were contacted? 19 A. You're asking me to recall my 20 conversation from a number of months ago. 21 I don't recall my conversation with any 22 specificity. In general I say send me 23 everything you have. And I think, to my 24 knowledge, that's been done. 25 Q. Okay. So the types of things</p>

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<p>1 you would want to review are medical 2 records?</p> <p>3 A. Yeah. Medical records that 4 were sent to me.</p> <p>5 Q. Okay. You'd want to -- at 6 least interview the patient and do a 7 patient history?</p> <p>8 A. Not necessarily. Sometimes I 9 can do things based upon record reviews.</p> <p>10 Q. Okay.</p> <p>11 A. Because it gets into the whole 12 analysis of, you know, when you deal with 13 any exposure case, any toxic tort case, 14 because mold is basically toxic tort cases. 15 They're in that category. Exposure, 16 general causation, specific causation. So 17 sometimes I can sort out these different 18 issues based just upon the records. 19 Sometimes I have to see the individuals. 20 It all depends upon the individual 21 circumstance.</p> <p>22 Q. Do you need to see the 23 individual's home?</p> <p>24 A. No. Not necessary -- Usually I 25 don't have to go -- Sometimes I'll be</p>	<p>1 to be able to critique and say, yeah, I 2 think this is satisfactory. And in this 3 case I believe what was done by Ms. Duncan 4 was satisfactory. So -- But usually the 5 person doing this -- obtaining the samples 6 is not an industrial hygienist. Sometimes 7 it may be. The analogy is in the hospital. 8 Say I need blood work done on Patient 9 Jones. Who obtains the blood sample is not 10 the physician. It's a phlebotomist. 11 Phlebotomist is a technician. The blood 12 sample is obtained by somebody other than 13 the learned professional who's the 14 physician. So very analogous in this 15 matter.</p> <p>16 Now, I believe that I have 17 sufficient understanding of the 18 circumstances here in the process engaged 19 in by Ms. Duncan; that is, taking samples 20 from the visible mold, tape samples, I 21 believe they were, and then sending those 22 utilizing proper chain of custody, which I 23 understand she did, to a testing laboratory 24 for the testing laboratory to analyze the 25 samples and report back that the samples</p>
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<p>1 called upon and asked to do an inspection. 2 And if it's not too far away, I'll do that 3 for the stated fee. If not, if I have to 4 travel some distance, it'll be an 5 additional fee. But, no, I can -- I can do 6 that -- do an analysis based many times 7 upon just the industrial hygiene records 8 that I'm provided, such as in this case. I 9 believe I have sufficient information to 10 render an opinion about whether or not -- 11 about the issues in this matter without me 12 personally inspecting the mattress and 13 personally obtaining the samples. And 14 usually I'm not the one called upon to do 15 that.</p> <p>16 Q. The person called upon to do 17 that, do you believe that should be an 18 industrial hygienist?</p> <p>19 A. It depends. I think in this 20 context you need -- what you need is -- to 21 comment upon it you need an industrial 22 hygienist. The person obtaining the 23 samples is usually not an industrial 24 hygienist. Many times it's a technician. 25 And then you need an industrial hygienist</p>	<p>1 are indication of cladosporium and that 2 there was heavy infestation of the sample. 3 I believe that that is perfectly fine and 4 satisfactory. I have absolutely no 5 questions, concerns, qualms about the mold 6 testing in this matter.</p> <p>7 Q. You say --</p> <p>8 A. And I'm saying that not just as 9 a doctor. Because just a doctor wouldn't 10 be qualified. I'm saying that as a doctor 11 that's also a certified industrial 12 hygienist and enough of a reputation in the 13 profession to be the president -- former 14 president of the first industrial hygiene 15 organization in this country, which was the 16 Michigan Industrial Hygiene Society. Why 17 Michigan Industrial Hygiene Society? 18 Occupational medicine industrial hygiene 19 really got their start in the Detroit area 20 because of the auto plants.</p> <p>21 Q. At different times in your 22 answer both used -- used both the singular 23 and the plural for sample and samples. Are 24 you -- Do you know how many samples 25 Ms. Duncan took?</p>

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<p>1 A. I don't know. I don't think 2 it's -- If she went and took one tape 3 sample, that would be satisfactory. If she 4 took multiple, fine. But if she took one 5 tape sample and it was representative of 6 what she saw as the mold contamination, I 7 believe that's satisfactory. And I would 8 call upon somebody else that's rendering an 9 opinion contrary to be able to support 10 their opinion with what would be a 11 recognized treatise.</p> <p>12 Q. Do you believe it would have 13 been important for somebody to take an air 14 sample of Mr. Simon's bedroom while he was 15 in it, sleeping in it, at the time that he 16 alleges he was sleeping on a Sleep Number 17 bed and it was contaminated from mold?</p> <p>18 A. No. First off -- no. It's not 19 relevant. Air sample. Why would you get 20 an air sample in some other portion of the 21 room? He's sleeping on a moldy mattress. 22 Okay? You know, the question of the mold 23 levels some place away from his -- Let the 24 record reflect that me putting my head down 25 on this table like somebody laying on a bed</p>	<p>1 the bed? You mentioned contact surface, 2 contact dermatitis.</p> <p>3 A. Do you have such samples? 4 Somebody did that with this particular 5 mattress, with this identity of 6 circumstances versus the circumstance where 7 your industrial hygienist did a testing 8 that, in my opinion, was -- appears to be 9 designed to minimize the mold exposure.</p> <p>10 Q. Well, the question is, is would 11 it matter to you if somebody had taken mold 12 samples on the surface of Mr. Simon's bed 13 and other portions of the bed?</p> <p>14 MR. CORWIN: Objection. Vague 15 as to time.</p> <p>16 THE WITNESS: Yeah. I mean, the 17 bottom line is -- bottom line is that I 18 believe the samples that were obtained were 19 proper. I don't think that you have to say 20 that in order for them to be proper to 21 document the mold contamination that you 22 have to do mold contam -- sampling at 23 the -- on the surface on his sheets. I 24 don't think that would necessarily be 25 representative of what his exposure would</p>
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<p>1 with his mouth right down by the surface of 2 the mattress, his body, dermal exposure to 3 the -- to the moldy mattress. Doing air 4 samples just is not, in my opinion, 5 relevant.</p> <p>6 Second problem with your 7 assertion is, wait a minute, how are we 8 going to go back in time? When he found 9 out that the -- By the time that he found 10 out that the mattress was moldy, my 11 understanding he stopped sleeping on it. 12 So how are we going to go back in time and 13 do air samples if they were, in fact -- had 14 any relevance prior to the time of his 15 discovery, because he didn't even know that 16 there was a moldy mattress. That's part of 17 the problem. He didn't know, and, 18 therefore, his doctors didn't know, and 19 that led him to have complication of 20 disease due to the inability of his doctors 21 to diagnose the cause or understand the 22 cause, because they didn't know about the 23 moldy mattress.</p> <p>24 Q. Would it be important to you if 25 somebody did mold samples on the surface of</p>	<p>1 be in over time, sleeping for now 2 apparently years on a moldy mattress. And 3 his manifestation of disease due to the 4 allergic exposure, and along with what your 5 expert allergist immunologist, Dr. Wedner, 6 believes that this is a highly-allergic 7 individual. If somebody is allergic to 8 mold, you can get manifestations of 9 allergic disease with minute exposures. 10 And his claim that somehow there's some 11 type of threshold, you need 3,000 -- It's 12 3,000 spores per meter cubed to have some 13 manifestation of disease, I just disagree 14 with that type of assertion.</p> <p>15 BY MS. FISHER:</p> <p>16 Q. If an individual is highly 17 allergic to cladosporium mold, wouldn't 18 they have manifestation when they walk 19 outside on a high mold spore count day?</p> <p>20 A. Again, he's the one that's 21 saying he's highly allergic. I'm saying 22 that he's fine now because he's not 23 sleeping on a moldy mattress 24 contaminated -- contaminated with 25 cladosporium. He was fine as far as his</p>

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<p>1 allergic manifestations before he was 2 sleeping on a moldy mattress. But when he 3 was sleeping on the moldy mattress, that's 4 when he developed manifestation of disease. 5 So that's my understanding of facts and 6 that allows -- that is part of the analysis 7 that allows me to opine in the, I believe, 8 the properly-trained specialty, 9 occupational and environmental medicine, to 10 determine causation of disease as it 11 relates to the mold exposure in this 12 matter.</p> <p>13 Q. If he was symptomatic to his 14 sensation -- sensitization. And correct me 15 if I'm wrong. I understand you can 16 allergic to something on a skin test. That 17 doesn't necessarily mean you'll be 18 symptomatic when exposed to that allergen; 19 is that correct?</p> <p>20 A. Again, such a vague question. 21 Let me state it this way. We know he was 22 symptomatic. He had problems when he was 23 sleeping on the moldy mattress. The 24 mattress was contaminated with 25 cladosporium. We know that based upon the</p>	<p>1 encounters those grasses and tree pollens?</p> <p>2 A. I don't differ with the 3 assertion that he has some type of allergic 4 sensitization, but he didn't have allergic 5 manifestation; that is, I think you're 6 making my point. He can be allergic to a 7 lot of things. He was fine when he wasn't 8 sleeping on the mattress contaminated with 9 mold. When he he's sleeping on the 10 mattress contaminated with mold, 11 unbeknownst to him, because it was a 12 latent, hidden defect, then he had 13 problems. So that's the point. And if, in 14 fact, he had problems -- if somebody is 15 trying to make an assertion, well, he's 16 allergic to pollen and he's allergic to 17 this and that, trees, and -- well, then why 18 isn't -- Why doesn't he still have the same 19 problems now because the same type of 20 pollens are -- the same type of pollens are 21 there that he was exposed to before he 22 bought the Select Comfort mattress, the 23 same type of pollens are there while he had 24 the Select Comfort mattress, and the same 25 type of pollens and tree allergens are</p>
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<p>1 testing. When he -- Before he started -- 2 Before the time period where the mattress 3 was moldy and he was sleeping on it, he 4 didn't have the allergic problems that he 5 had. Then when he stops -- When he 6 discovered the moldy mattress and he stops 7 sleeping on it, his symptoms either 8 completely resolved from allergic disease 9 or largely resolved. I believe that 10 that -- that is consistent with my analysis 11 of causation. That's the only way I can 12 answer the question. Because otherwise the 13 question is just so vague, you know. 14 Again, we're not talking in vagaries. 15 We're talking about this particular case 16 and my analysis in this case.</p> <p>17 Q. Well, let me give you a 18 hypothetical that applies to Mr. Simon. 19 He's allergic to, according to his skin 20 test, multiple types of grass and tree 21 pollens.</p> <p>22 A. Mm-hmm.</p> <p>23 Q. Is it possible that he is 24 sensitized to grass and tree pollens, but 25 he may not be symptomatic when he</p>	<p>1 there after he discovered the mold on the 2 Select Comfort mattress and stopped 3 sleeping on it. So how does pollen, tree 4 allergens, how does that figure into that? 5 Now I'll leave that to your expert to 6 explain that, but the picture doesn't fit. 7 And it's a matter of having the picture 8 fitting that is part of the deductive logic 9 process of a differential diagnosis of 10 etiology. Again, and that whole issue is 11 described in the Reference Manual of 12 Scientific Evidence, Third Edition.</p> <p>13 Q. Let me try to ask you the 14 question a little bit more clearly.</p> <p>15 Mr. Simon is, I'm just going to 16 pick one that he is sensitized to, 17 according to the skin test that you just -- 18 that you reviewed a little while ago. I'm 19 going to pick spiny pigweed, because I like 20 how it sounds. Is it your understanding of 21 the allergy response and the way that the 22 human body may or may not respond to 23 something that it's sensitized to, that you 24 can have a reaction to spiny pigweed on 25 your skin, on your skin test that you</p>

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<p>1 reviewed, but somebody can wave it all 2 under your nose and you actually won't be 3 symptomatic of that. You won't -- you 4 won't have any outward symptoms of that 5 allergy. Is that your understanding of 6 the --</p> <p>7 A. It all depends upon the amount 8 of allergic sensitization, what the 9 exposure is. A lot of people aren't 10 allergic to tobacco, okay. And they can be 11 allergic to it and be in a room by somebody 12 smoking a cigarette and have allergic 13 symptoms or not. Maybe some people can 14 smoke and be allergic and have allergic 15 symptoms or not. It depends on the extent 16 of their sensitization and a reaction to 17 the sensitization. So, you know, it's -- 18 it gets down to what are the facts.</p> <p>19 Q. So, in your opinion, Mr. Simon 20 is not only allergic on his skin test to 21 cladosporium, but also has -- when exposed 22 to cladosporium he has -- he's symptomatic. 23 He has allergic reactions to it?</p> <p>24 A. No. This is my opinion. My 25 opinion that he had symptomatology when he</p>	<p>1 not having the problems that -- now that he 2 had when he was sleeping on the moldy 3 mattress. He didn't have the problems that 4 he had when he was sleeping on the moldy 5 mattress before he was sleeping on the 6 moldy mattress. What were the factors? 7 Sleeping on a moldy mattress with 8 cladosporium. That's the difference in 9 exposure versus cladosporium in the air. 10 He had cladosporium in the air at the time, 11 if it's properly seasonal, when he was 12 sleeping on the moldy mattress. He has 13 exposure in the proper season to 14 cladosporium in the air when he's not 15 sleeping on the moldy mattress. But the 16 factor that led to the -- the circumstance 17 that led to his manifestation of disease 18 was sleeping on the moldy mattress.</p> <p>19 Q. So it's your opinion that it's 20 a matter of exposure level?</p> <p>21 A. No, no. It's my opinion 22 it's -- In his case, it was sleeping on a 23 moldy mattress. It isn't a matter of 24 exposure level or not. It's that he was 25 sleeping on a moldy mattress and he's -- he</p>
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<p>1 was sleeping on a mattress, moldy mattress, 2 that included clado -- that included, 3 appears to be, cladosporium contamination. 4 And then he had an allergic manifestation 5 due to that. Now, there is cladosporium in 6 the environment. There's cladosporium in 7 this air. It's, I believe, the most common 8 mold, outdoor mold, in North America. 9 That's my recollection. So he may be 10 allergic to cladosporium. There may be 11 plenty of cladosporium in the air in 12 St. Louis. There was plenty of 13 cladosporium in the air in St. Louis now 14 after he's no longer sleeping on the moldy 15 mattress. There was plenty of cladosporium 16 in the air in St. Louis before he was 17 sleeping on the moldy mattress. But its 18 manifestation of disease, allergic disease, 19 happened when he was sleeping on the moldy 20 mattress. So somebody is trying to sit 21 down and say, well, you know -- I'll let 22 somebody -- I'll let your expert explain 23 why that factors into their analysis. I've 24 just told you why I think that -- you know, 25 you can be allergic to cladosporium. He's</p>	<p>1 is -- had allergic manifestation of disease 2 due to sleeping on the moldy mattress. 3 Now, he may have allergies to cladosporium, 4 but he's not sleeping on a moldy mattress 5 anymore, so he's not having problems. It's 6 as simple as that.</p> <p>7 Q. Well, I don't find that simple 8 because you say it's not due to exposure 9 level.</p> <p>10 A. No, no, no, no, no.</p> <p>11 Q. But you say that the -- explain 12 to me why the cladosporium in the air will 13 not affect him, but the --</p> <p>14 A. I understand. Okay. I 15 understand. I think I understand.</p> <p>16 There are no exposure limits 17 for biologics. If you go to OSHA, there is 18 a permissible exposure limit to chemicals. 19 Like carbon monoxide, the permissible 20 exposure limit to carbon monoxide is 35 21 parts per million. Because we know that, 22 you know, some people are going to have 23 problems below that. But from a societal 24 standpoint we have decided that, you know, 25 some people are going to have problems</p>

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<p>1 below 35 parts per million to carbon 2 monoxide, but we still have to have some 3 exposure to carbon monoxide in our society. 4 There are no such analogous 5 exposure limits for biologics such as mold. 6 Because if you're allergic to mold, even 7 one mold spore could cause you to have 8 adverse allergic reaction. Even one mold 9 spore could cause a susceptible individual 10 to have an anaphylactic reaction. Even one 11 exposure to other biologics could cause 12 such a reaction. That is why there are no 13 exposure limits within -- for biologics 14 within industrial hygiene. There are 15 exposure limits to other chemicals -- to 16 chemicals and other substances, but not to 17 biologics. 18 So your question can't be 19 answered that way because it assumes that 20 there are levels. That's not how the 21 analysis is done as far as biologics, 22 including mold. So there's a false premise 23 in your question. And I'm not saying that 24 to insult you. It's just that there's a 25 false premise in your question.</p>	<p>1 standpoint, because there are none because 2 even a minute quantity of allergic 3 substance can cause somebody to have 4 serious disease or death. That's why when 5 you get on an airplane and some kid has 6 peanut allergies on the plane, they just -- 7 the airline doesn't let the peanuts be 8 distributed. Because even a minute amount 9 could cause somebody that's -- that has a 10 severe allergy to peanuts to go into 11 anaphylactic shock and die. And I have, 12 contrary to what Dr. Wedner is saying, I've 13 seen that happen, okay? So even a small 14 amount of a substance to which somebody is 15 highly allergic to can cause serious 16 disease and death. 17 In this case, we're not talking 18 about Mr. Simon having anaphylactic shock. 19 We're talking about him having allergic 20 disease manifested from sleeping on a moldy 21 mattress for years because he didn't know 22 about it. But the serious disease like 23 anaphylaxis that can happen with even a 24 minute quantity is why there are no 25 biologic exposure limits to mold, other</p>
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<p>1 Q. Well, I think you may have 2 misunderstood the question. Because I 3 wasn't asking for a number or a cutoff. 4 I'm asking for a relative comparison. 5 So is it your opinion that a 6 relative -- with respect to relative 7 comparison he was exposed to a higher level 8 of mold by sleeping on the mattress than 9 he's exposed to when he goes outside during 10 the mold season? 11 A. Level is the wrong word to use. 12 He had a different exposure circumstance. 13 There are no -- You don't use levels when 14 you're talking about biologics. That's 15 part of the problem with your expert's 16 opinion. His opinion is not consistent 17 with what would be generally accepted. It 18 is junk science, Dr. Wedner. He may be a 19 well-educated man, but it's junk science. 20 There are no levels for biologics. That's 21 part of the reason why what he's saying is 22 junk science. And let him defy that 23 opinion I've just said by showing me what 24 the exposure limits are for biologics from 25 an occupational environmental exposure</p>	<p>1 biologic substances, you know, organic 2 substances like that. And so when you 3 start using the term levels, it's just the 4 wrong use of the term. That's why your 5 wrong -- you got the wrong type of expert 6 in an allergist immunologist. If you'd 7 hired an occupational medicine doctor, I 8 think they'd probably have to agree with 9 me. And even if they didn't, they'd have 10 the right specialty. Dr. Wedner is the 11 wrong specialty. Because if he was the 12 right specialty, he would have never said 13 anything as absurd as he said. It's just 14 the wrong type of doctor. Not saying he 15 isn't a fine allergist and immunologist, 16 but he's not -- You picked the wrong 17 expert. If anybody is talking about 18 levels, it's the wrong use of word in this 19 matter. 20 Q. Put aside the word level. 21 I'm still somewhat confused by an opinion 22 that would state that Mr. Simon was 23 symptomatic while he was laying on the 24 mattress but can -- would not be 25 symptomatic when exposed to cladosporium</p>

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1 when he goes into the outside air?
 2 A. Why are you puzzled by that?
 3 He was symptomatic when he was sleeping on
 4 the mattress. The mattress was
 5 contaminated with mold. Now he's not
 6 sleeping on the mattress. There's still
 7 cladosporium in the air. He's not
 8 symptomatic. That's the fact. That's how
 9 it is. Why is that? Sleeping on a moldy
 10 mattress is a different circumstance than
 11 having just cladosporium in the normal air.
 12 I don't see what is so difficult with that
 13 concept. And I think a jury is going to
 14 sit down and they're -- you know, the lay
 15 jury is going to have the same thought that
 16 I have in that context. Now, you need an
 17 expert to testify to these issues, but I
 18 don't -- I'm surprised that you're
 19 surprised. I really am.
 20 Q. Can you explain to me how it's
 21 a different circumstance?
 22 A. You're sleeping on a moldy
 23 mattress. The mattress is moldy. That is
 24 different than not sleeping on a moldy
 25 mattress.

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1 Q. Are you familiar with where the
 2 mold was allegedly located in the mattress?
 3 A. Yes, I am.
 4 Q. You're familiar it was located
 5 inside the mattress and not on the outside
 6 of the mattress?
 7 A. Ma'am, I'm prepared to testify
 8 as a biomedical engineer about the design
 9 defects in this. I have enough
 10 understanding of the circumstance. And I
 11 believe in this context he would have had
 12 exposure. That you would have had from
 13 compression of the mattress, being on the
 14 mattress, the moldy mattress, the material,
 15 that there's no -- there is no material
 16 like an impermeable barrier between the
 17 mold inside the mattress and his exposure.
 18 Part of the reason why you have mold is
 19 that there's an impermeable barrier to keep
 20 vapor from penetrating through. A normal
 21 bed, it would just penetrate through. It
 22 would just continue to go through, and you
 23 wouldn't have liquid water formation at the
 24 point as you have with an impermeable
 25 barrier. So -- But he's going to have

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1 exposure due to this. And I think any
 2 assertion by an individual saying
 3 otherwise, I leave them to sit down there
 4 and support their opinion and support their
 5 opinion with literature that would say
 6 contrary. I believe that this clearly
 7 would have led to his exposure. You push
 8 down on that mattress, you push down on the
 9 mattress, push down on any mattress, you
 10 feel like a little whoosh of air come back
 11 up.
 12 Q. So --
 13 A. That's what would have happened
 14 with this mattress, and that little woof of
 15 air would have had -- would have had fungal
 16 particles coming back up, and you would
 17 have had exposure. And there is no
 18 impermeable barrier between him, his
 19 exposure to his skin, the respiratory
 20 exposure, nasal and other airway to the
 21 mold because this is different than your
 22 initial analogy where you said you took a
 23 moldy material and you put it into a bag,
 24 impermeable bag, and had it wrapped up;
 25 and, you know, is somebody going to get

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1 exposed. That's not the case here. The
 2 case here is that there is no impermeable
 3 barrier.
 4 Q. So it's your opinion then or
 5 you theorize that the mold spores and
 6 particles from inside the bed became
 7 aerosolized and came outside the bed?
 8 A. No, no. It didn't have to get
 9 outside the bed. All we had to do is have
 10 skin contact to the substance that he's
 11 allergic to. Even in minute quantities you
 12 can have allergic manifestation. Now, I
 13 don't say that it was minute quantities.
 14 He's sleeping on a moldy mattress, and he
 15 had allergic manifestations as a result.
 16 So I know that there's some theory
 17 that's -- your expert is trying to
 18 formulate that says that, no, he would not
 19 have had mold exposure to any mold
 20 particles because it's deep in the
 21 mattress. And somehow Dr. Wedner is saying
 22 that the mold spores have to germinate in
 23 order for people to have any type of
 24 allergic disease. I think that's all --
 25 that is junk science. And I'll leave your

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1 experts to support their opinion with
2 peer-reviewed literature, just like I've
3 been able to do at every point of this
4 process when called upon do so.

5 Q. I'm still -- I just want to
6 make sure I'm clear on what your testimony
7 is with respect to -- you've testified that
8 there has to be exposure in general?

9 A. Yes. You have to have exposure
10 in order to have the disease due to
11 exposure, yes.

12 Q. And it's your testimony that
13 lying on the bed gave him exposure?

14 A. Yeah. A mattress contaminated
15 with mold gave him exposure.

16 Q. And exposure was both through
17 contact through his skin, was one type of
18 exposure; and the other type of exposure
19 was breathing in the spores?

20 A. And/or both.

21 Q. And/or both. So those are the
22 two methods of exposure that you're basing
23 your opinion on?

24 A. The only one I can think of is
25 that. I don't see any ingestion. And I

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1 of disease that led to the issues in this
2 case. And before he was sleeping on that
3 moldy mattress, he didn't have that
4 allergic manifestation of disease. And
5 after he was done sleeping on the moldy
6 mattress, he did not have the same allergic
7 manifestation of disease. So that ties in
8 with the differential diagnosis of
9 etiology, the recognized scientific
10 methodology for a physician to use in this
11 matter, and specifically an occupational
12 medicine physician to sort out and
13 formulate a differential diagnosis of
14 etiology as to the cause of the disease,
15 and that leads me to the mattress.

16 Now, I'll let your experts
17 explain what you're trying to say is, well,
18 gee whiz, Doc, I can't understand. He's
19 allergic. Why isn't he allergic when he's
20 out in the air and he's not sleeping on the
21 moldy mattress? Well, he's not. And
22 that's not -- That's not what's happening
23 to him. So he doesn't have the same
24 manifestation of allergic disease if he's
25 not sleeping on the moldy mattress. So,

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1 don't think he was injecting mold into him
2 intravenously. So it's dermal and/or
3 respiratory.

4 Q. If he was symptomatic when
5 coming in contact with mold spores, either
6 through dermal means or respiratory means,
7 he would be symptomatic if he came into
8 contact with cladosporium again in one of
9 those two or in combination?

10 A. No. Not necessarily. Sleeping
11 on a moldy mattress is different than a
12 circumstance where you're not sleeping on a
13 moldy mattress. So I think what you keep
14 on trying to come back to is he would have
15 some allergic manifestation of the same
16 time when he comes into contact with
17 cladosporium and there's cladosporium in
18 the air; and, therefore, this is all
19 nonsense. That's what your experts are
20 saying. And I'm saying, no, that's wrong.
21 Sleeping on a moldy mattress is different
22 than the same circumstance with him where
23 he's not sleeping on the moldy mattress.
24 And when he was sleeping on the moldy
25 mattress he had the allergic manifestation

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1 you know -- And that's how it is.
2 Sometimes, you know -- So he's not having
3 the same exposure circumstance not sleeping
4 on the moldy mattress as when he was
5 sleeping on the moldy mattress.

6 Q. Do you have any cases in this
7 list in Exhibit 1 or others in your history
8 that you can tell me about in which you've
9 opined about some sort of disease or toxic
10 substance related to mattresses before?

11 A. No. I don't -- I don't recall
12 any. If I -- if there is, I don't recall
13 any offhand. I doubt -- Obviously I deal
14 with issues, and I deal clinically with
15 issues with mattresses, because I used to
16 be, in addition to caring for individuals
17 with catastrophic injuries, quadriplegics
18 and severe head injuries in the home care
19 setting, I was, for over ten years, the
20 medical director of the visiting nurses of
21 Southeast Michigan, which was the largest
22 and oldest not-for-profit nursing
23 organization in the state of Michigan. It
24 was founded in 1898. So I have more than
25 the average physician's understanding of

36 (Pages 138 to 141)

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1 beds. Because you have to have that if
2 you're dealing with home-bound people and
3 people that are susceptible to disease that
4 can be caused by beds like decubitus
5 ulcers. And I am, of course, a biomedical
6 engineer. But I don't recall offhand any
7 testimony on that testimony list that has
8 specifically to do with mattresses. But
9 then again, that doesn't mean that I don't
10 have my knowledge, training, and experience
11 that would be relevant in this matter if
12 called upon to testify about specifically
13 the mattress and the biomedical aspects --
14 biomedical engineering aspects of the
15 mattress. The fact that I haven't
16 testified on that issue before doesn't mean
17 I don't have expertise.

18 Q. Let's go back to -- We had
19 talked about what you do, your different
20 practices. Do you try cases right now?

21 A. Yeah. I have tried toxic tort
22 cases, and I have been an attorney in
23 various toxic tort cases. And I have tried
24 administrative law cases also.

25 Q. Have you tried any in the last

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1 five years?

2 A. Yes. The last five years. I
3 tried one in California in 2009. It was a
4 toxic court case in Sacramento, California.
5 Since that time I have not had a case that
6 went to trial. And it's not a major
7 portion of my practice. I do it from time
8 to time.

9 Q. Okay. And I think that we
10 established that the majority of your
11 income is derived from expert services?

12 A. Well, again, I don't -- That's
13 my impression. I won't differ with the
14 assertion that 90 percent or more comes
15 from being a forensic expert. But I don't
16 really know with absolute certainty that
17 that's the case, because I don't -- I'm a
18 numbers guy. I don't just guess at
19 percentages. That implies -- percentage
20 implies some type of precision.

21 (Document marked as Dr.
22 Chiodo Exhibit No. 7 for
23 identification.)

24 BY MS. FISHER:

25 Q. Do you recall this article that

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1 it looks like you were interviewed for
2 earlier this year?

3 A. Yes. It looks like I'm a
4 distinguished alumnus of Wayne State
5 University Law School.

6 Q. Have you seen this before?

7 A. Yes. Most definitely. I'm
8 very proud of this. Contact -- Wayne State
9 contacted me because they wanted to write
10 an article about me. Wayne State
11 University Law School.

12 Q. So on the second page, and I
13 understand that this is a printout from
14 a -- from the internet, so the pages might
15 be a little funny. Just over halfway down
16 right after seven questions, this article
17 states that you actively practiced both
18 medicine and law. And it says, quote, but
19 his primary source of income is his work as
20 a forensic medical expert witness for
21 trials. Is that true?

22 A. Isn't that consistent with my
23 testimony?

24 Q. I'm not suggesting it isn't.
25 I'm just asking is that true?

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1 A. Yeah. I believe so. That's my
2 impression.

3 Q. And then the --

4 A. Now, they didn't ask me under
5 oath to sit down and throw out a
6 percentage. But I think -- I think my main
7 focus is as a forensic medical expert; just
8 like a forensic pathologist, 100 percent of
9 their time is as a forensic expert.
10 Because you don't want to have a country
11 doctor figuring out if somebody was
12 murdered or not.

13 So I have expertise most
14 physicians don't have, and it comes into
15 play with forensic issues. So that's most
16 of what I do. I'm very proud of it. I'm
17 not an amateur doing this. I'm -- This is
18 what I do. It's like the guys on CSI.
19 They're doing -- They're not taking care of
20 sore throats and then going and doing their
21 forensic analysis. I do take care of a few
22 sore throats still, because I still have a
23 clinical practice. But most of what I do
24 is forensic medicine. Because that's --
25 because I have that type of background.

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1 Q. And the quote just below that
2 paragraph. "That's my main activity and
3 it's very lucrative?"
4 A. That's a fact.
5 Q. That's your quote?
6 A. That's my quote. It is my --
7 That's my main activity and I would have --
8 I think anybody would agree \$1,000 an hour
9 testifying is lucrative. And I would agree
10 with that.
11 Q. How many cases do you take on
12 in a year roughly?
13 A. I don't keep a log. I don't
14 know. It's something I do. I do a lot of
15 forensic work, but I can't quantify it.
16 Q. Is it so many that you need to
17 have an agency manage your work?
18 A. No. I don't think an agency
19 manages my work. There are different
20 companies and agencies that will look for
21 expert witnesses in different issues, and
22 there'll be a middleman between me and the
23 ultimate person desiring the expert witness
24 work. But I'm -- I manage everything
25 myself.

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1 Q. Do you market your services?
2 A. Who doesn't? Who doesn't?
3 Hospitals market their services. Doctors
4 market their services. I mean who doesn't?
5 I mean we're, you know, that's -- Who
6 doesn't? So yes, of course I market my
7 services. I don't market a lot. I mean I
8 don't spend a lot of time in marketing. I
9 have the type of background the work comes
10 to me. But I do have listed on expert
11 witness directories people are able to find
12 me via the internet. And, of course, word
13 of mouth.
14 Q. Do you know how the plaintiff's
15 attorney in this case found you?
16 A. No.
17 Q. Have you ever worked with him
18 before?
19 A. No.
20 Q. Have you ever worked for the
21 firm Sher Corwin Winters before?
22 A. No.
23 (Document marked as Dr.
24 Chiodo Exhibit No. 8 for
25 identification.)

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1 THE WITNESS: Actually, I think
2 we're going over time.
3 MR. CORWIN: We're fine. I'll
4 monitor it.
5 THE WITNESS: That's fine.
6 MR. CORWIN: I appreciate you
7 thinking about me.
8 THE WITNESS: Yes, ma'am. I'm
9 at your service. You go right ahead.
10 BY MS. FISHER:
11 Q. Do you know who Prime Time
12 Legal Services Agency is?
13 A. Yes. This is -- This is an
14 interesting guy. This is a classmate of
15 mine from business school, at the
16 University of Chicago Business School. And
17 I ran into him. Because I'm the -- I'm one
18 of the -- I'm the co-chairman of the
19 University of Chicago Booth Health Care and
20 Biopharma Round Table. And -- I happen to
21 run into him at the University of Chicago's
22 Gleacher Center campus, and he asked me
23 what I did, and I told him. He had known
24 of me before from business school. And he
25 said, well, God, I'd like to market your

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1 services. I said, feel free to do so. Now
2 more than that, I don't know. He put out
3 whatever he put out. This is not something
4 that I put together. I haven't received
5 any work from him. I don't know if he
6 defamed me in this at all. Let me know if
7 you think he defames me. But, you know,
8 somebody -- somebody marketing my services.
9 And I don't have a problem with somebody
10 doing that. That's perfectly fine and they
11 put a markup on it. That's called American
12 business.
13 Q. In your South Florida business
14 do you have a web page in which people who
15 believe they've been injured by mold can
16 write in, fill out a questionnaire, and
17 send it in to you?
18 A. If it's termed that people
19 injured, I would say people that have
20 issues concerning mold or toxins. It's not
21 solely plaintiffs. In fact, I do a lot of
22 work and analysis on behalf of defense in
23 Florida. And they find me through that
24 website. So your -- I disagree with your
25 assertion that it's somehow geared towards

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<p>1 plaintiffs. It's geared towards anybody 2 that has this concern. It's pretty hard to 3 find somebody with the right expertise 4 concerning toxicology and mold anywhere, 5 and including South Florida. So I -- 6 (Document marked as Dr. 7 Chiodo Exhibit No. 9 for 8 identification.) 9 BY MS. FISHER: 10 Q. Is this a printout of the page 11 of your website in South Florida, Mold and 12 Toxicology Center? 13 A. Yes, ma'am. It looks like it. 14 Exhibit 9. Yes, ma'am. 15 Q. On the left-hand side our 16 focus, the first bullet is, or I guess it's 17 not a bullet, the first statement is mold 18 and building illness. 19 A. Yes. 20 Q. If you click on this link learn 21 more, is that where the, to your knowledge, 22 is that where the form pops up that people 23 can write to you and ask for your 24 consulting services? 25 A. I don't know. I didn't put</p>	<p>1 identify it. 2 (Document marked as Dr. 3 Chiodo Exhibit No. 10 for 4 identification.) 5 BY MS. FISHER: 6 Q. Is this also a printout of the 7 website from South Florida Mold and 8 Toxicology Center? 9 A. It looks like it. 10 Q. Okay. Let's go off the record 11 for one minute. 12 (Discussion had off the 13 record.) 14 (Short break taken.) 15 BY MS. FISHER: 16 Q. I have one question. Are you 17 familiar with what a confounder is? 18 A. Confounder is an epidemiologic 19 term that has to do with one circumstance 20 going along with another circumstance that 21 is the actual cause. The classic example 22 of a confounder is if you look at the rates 23 of homicide in a city and the rates of ice 24 cream consumption, the rates of homicide 25 will go up as the rates of ice cream</p>
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<p>1 together the website. And I'm not a 2 techie. I'm not a web type of person, 3 so -- 4 Q. But you understand -- 5 A. I won't differ with your 6 assertion. I don't -- By the way, if 7 somebody tries to communicate with me 8 through via e-mail, that's not how I do it. 9 If they want to contact me -- and I guess 10 that's the modern way. Usually I prefer 11 somebody calls me. If somebody sends me 12 something about mold, I'll say -- you know, 13 call them up and say, I'd be happy to talk 14 to you. But I don't -- I don't communicate 15 back and forth with e-mail. If that's 16 contact access point, I'm not differing 17 with the assertion. I don't know. I 18 didn't put together the website, and I 19 don't spent a lot of time horsing around 20 with it. I do market, but I don't have to 21 put a lot of time into marketing. I do not 22 have to put a lot of time into market. 23 Q. And I apologize. I lied when I 24 said I promise, because I actually do have 25 a copy of this, and I just want you to</p>	<p>1 consumption go up. Well, in that case, ice 2 cream is not causing people to commit 3 homicides. It isn't the sugar rush. It's 4 because ice cream consumption goes up in 5 sales when the weather is hot. And when 6 the weather is hot, people are outside, 7 they're -- it's hot, they're agitated, 8 they're more likely to commit homicides. 9 That's an example of a confounder. 10 Q. I have nothing further today. 11 MR. CORWIN: Read and sign or 12 waive? 13 THE WITNESS: I don't care. 14 It's up to you. I prefer to waive. 15 MR. CORWIN: Okay. We'll waive. 16 (Witness excused.) 17 * * * * * 18 19 20 21 22 23 24 25</p>

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1 STATE OF ILLINOIS)
2) SS.
3 COUNTY OF COOK)
4

5 I, LAURA MUKAHIRN, Certified
6 Shorthand Reporter and Notary Public in and
7 for the County of Cook, State of Illinois,
8 do hereby certify that on August 20, 2015,
9 the deposition of the witness, DR. ERNEST
10 CHIODO, called by the Defendant, was taken
11 before me, reported stenographically, and
12 was thereafter reduced to typewriting under
13 my direction.

14 The said deposition was taken at
15 the offices of 227 West Monroe Street,
16 Chicago, Illinois, and there were present
17 counsel as previously set forth.

18 The said witness, DR. ERNEST
19 CHIODO, was first duly sworn to tell the
20 truth, the whole truth, and nothing but the
21 truth, and was then examined upon oral
22 interrogatories.

23 I further certify that the
24 foregoing is a true, accurate, and complete
25 record of the questions asked of and
answers made by the said witness, DR.

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1 ERNEST CHIODO, at the time and place
2 hereinabove referred to.

3 The undersigned is not
4 interested in the within case, nor of kin
5 or counsel to any of the parties.

6 Witness my official signature
7 and seal as Notary Public, in and for the
8 County of Cook, State of Illinois, on this
9 25th day of August A.D., 2015.
10

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Laura Mukahirn

LAURA MUKAHIRN, CSR
CSR NO. 084-003592



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